Norovirus Testing Requirements

The Michigan Department of Health and Human Services (MDHHS) is here to assist local health departments (LHD) investigate potential norovirus outbreaks. The MDHHS Bureau of Laboratories (BOL) offers norovirus PCR testing of stool specimens. Testing is for the investigation of norovirus outbreaks only. Physicians cannot request testing of an individual for diagnostic purposes.

Due to limited resources, norovirus testing must be pre-approved by the Bureau of Disease Control, Prevention, and Epidemiology (BDCPE). The following requirements must be met before testing may proceed.

1. Complete the ***Initial Cluster and Facility Outbreak Notification Report Form***, which includes the following epidemiologic information:

- Number of ill cases (e.g. patrons, patients, residents, employees)
- Symptoms
- Onset date
- Average duration of illness
- Facility characterization (e.g. school, healthcare center, or restaurant)

2. Contact Jennifer Beggs, Shannon Johnson, or Brenda Brennan with the MDHHS BDCPE at 517-335-8165 to obtain testing approval and shipping instructions.

3. If testing is approved, collect 3 – 6 specimens from symptomatic cases only. The upper limit for collection from an ill individual is 10 days post onset of symptoms.

4. Cases must live in separate households unless the outbreak is occurring in a healthcare or residential facility.

5. Specimens must be collected in clean, sealable containers without preservative (e.g. no Cary Blair). Leaking specimens will not be tested.

6. Specimen containers must be labeled with:
   - Case's name and date of birth
   - Date of collection
   - Outbreak identifier

7. Outbreak identifiers should include the month and year. For example, "Smith Reception 05/12".

8. If specimen containers are left with a client, make sure the collection container is properly sealed and labeled prior to mailing.

9. Submit specimens with a completed BOL test requisition form (DCH-0583). Each specimen will need its own form. Please complete the back of the form (#6. Outbreak Investigation):

http://www.michigan.gov/documents/DCH-0583TEST_REQUEST_7587_7.pdf

10. Contact Jennifer Beggs, Shannon Johnson, or Brenda Brennan with the MDHHS BDCPE at 517-335-8165 to report how many samples were collected and when specimens will be shipped. This information must be provided prior to shipping of specimens.

11. All specimens from an outbreak must be batched and sent together with coolant pack.

12. Delivery of specimens to the laboratory must occur Monday–Friday during normal business hours.

SAMPLES THAT ARRIVE WITHOUT PROPER LABELING, COMPLETED TEST REQUISTIONS OR SUBMITTER INFORMATION WILL NOT BE TESTED AND WILL BE DISCARDED DUE TO CAP REQUIREMENTS.

Since norovirus outbreaks occur unexpectedly, it is suggested that LHDs prepare for outbreaks before they occur. Planning ensures accurate and timely responses. Identify your LHD specimen courier or shipping company (e.g. FedEx, UPS) and order/stock specimen collection kits prior to an outbreak occurring. Collection kits (Unit #46 Foodborne Illness Kit) can be order through the MDHHS Laboratory Support Unit. Please contact Mark Warstler at warstlerm1@michigan.gov or 517-335-9037 or for more information.

Specimen test results will be released to the LHD via fax and through the Michigan Disease Surveillance System (MDSS). ■

Outbreak Identifier:

MI Outbreak ID Number:

County:

NORS ID:

Date:

☐ Initial Report

☐ Final Report

Cluster and Facility Outbreak Notification Report Form

Type of Outbreak: ☐ Gastrointestinal ☐ Respiratory ☐ Rash ☐ Other:_____

Person Providing Report:

Name:		Phone:	
E-mail:		Alt Phone:	

Facility Information:

Facility Name:			
Address:			
Facility Contact Person:		Phone:	
Affected Unit(s)/ Floor(s):			

Type of Facility:

☐ Healthcare (Please specify)
- ☐ Acute Care
- ☐ Assisted Living
- ☐ Critical Access
- ☐ Long-term Acute Care
- ☐ Long-term Care/ Nursing Home
- ☐ Outpatient (e.g., dialysis center, ambulatory surgical center)

☐ Adult Day Care

☐ Child Day Care/ K-12 School

☐ Event (e.g., wedding, party, funeral)

☐ Restaurant

☐ Senior Apartments/ Retirement Center

☐ College / University

☐ Other: _____

Epidemiology:

***"Int" = Initial Case Count**

Onset Date of First Case:			Date of Last Onset:		
Duration (range, average):			Incubation Period (range, average):		
Suspected Etiology:					
Total Number Ill:	Int:	Final:	Number of Secondary Cases:	Int:	Final:
Adults:	Int:	Final:	Hospitalized Cases:	Int:	Final:
Children:	Int:	Final:	Deaths:	Int:	Final:
Ill Employees:	Int:	Final:	Ill Residents/ Patients:	Int:	Final:
Total Employed:	Int:	Final:	Total Population:	Int:	Final:
Ill Food Handlers:	Int:	Final:	Ill Visitors:	Int:	Final:

Symptom Presentation:

Symptom(s)	Symptom Present?	Number of Cases with Symptom	Total # of Cases with Information Available
Vomiting	☐ Yes ☐ No		
Diarrhea	☐ Yes ☐ No		
Nausea	☐ Yes ☐ No		
Abd Cramps	☐ Yes ☐ No		
Fever º_____ (highest recorded)	☐ Yes ☐ No		
Bloody Stools	☐ Yes ☐ No		
Respiratory (e.g., coughing, wheezing)	☐ Yes ☐ No		
Pneumonia	☐ Yes ☐ No		
Rash	☐ Yes ☐ No		
Itching	☐ Yes ☐ No		
Skin and soft tissue wound/damage	☐ Yes ☐ No		
Other :	☐ Yes ☐ No		

Specimen Testing:

☐ Declined

☐ Stool- Norovirus

☐ Stool - Bacterial

☐ Stool - Ovum and Parasites

☐ Respiratory Swab/ Secretion: _____

☐ Blood: _____

☐ Wound/Skin Cultures: _____

☐ Food: _____

☐ Other: _____

No. of Specimens Collected	Test Ordered	Laboratory Performing Tests	Shipping Date	Results

Consultation Provided:

Date Prevention and Control Actions Initiated: _____

☐ Environmental cleaning guidelines

☐ Employee restrictions

☐ Visitor restrictions

☐ Specimen collection and submission

☐ Infection control precautions

☐ Patient cohorting, isolation, and restrictions

☐ Closed units to transfers and admits

☐ Other:_____

Additional Actions and Notifications:

☐ Local Health Department

☐ MDHHS Bureau of Laboratories

☐ MDARD

☐ MDHHS Public Information Officer

☐ MDLARA Bureau of Health Systems

☐ Federal Agencies:

☐ CDC ☐ FDA ☐ USDA

☐ Other:_____

This information may be reported to the MDHHS Division of Communicable Diseases by telephone (517) 335-8165 or fax (517) 335-8263

MICHIGAN DEPARTMENT OF HEALTH and HUMAN SERVICES• BUREAU OF LABORATORIES

MICROBIOLOGY/VIROLOGY TEST REQUISITION

P.O. Box 30035 • 3350 North Martin Luther King Jr. Blvd. • Lansing, Michigan 48909

Laboratory Records: (517) 335-8059 • Fax: (517) 335-9871 • Technical Information: (517) 335-8067 • Web: http://www.michign.gov/mdhhslab

DATE RECEIVED AT MDHHS

MDHHS SAMPLE #

AGENCY - SUBMITTER INFORMATION

ENTER STARLIMS AGENCY CODE

RETURN RESULTS TO

FP ☐

STD ☐

PHONE (24/7)

FAX

PHYSICIAN OF RECORD/LEGALLY AUTHORIZED PERSON ORDERING TEST

NATIONAL PROVIDER IDENTIFIER

PATIENT INFORMATION - NAME (Last, First, Middle Initial or Unique Identifier) Must Match Specimen Label Exactly

SUBMITTER'S PATIENT NUMBER (If Applicable)

PATIENT'S CITY OF RESIDENCE

ZIP CODE

GENDER ☐ M ☐ F

RACE

☐ Black/AA ☐ White ☐ Native American or Alaskan ☐ Asian ☐ Hawaiian/PI ☐ Unknown ☐ Other (Specify)

ETHNICITY ☐ Hispanic ☐ Arab Descent ☐ UNKNOWN

DATE OF BIRTH (MM/DD/YYYY)

SUBSCRIBER INFORMATION ☐ Medicaid ☐ ADAP ☐ DOC ☐ Other:

SUBSCRIBER NUMBER

SUBMITTER'S SPECIMEN NUMBER (If Applicable)

DATE COLLECTED (MM/DD/YYYY)

TIME COLLECTED ☐ AM ☐ PM

INDICATE SPECIMEN SOURCE

- ☐ BRONCHIAL
- ☐ CERVIX
- ☐ CSF
- ☐ GASTRIC
- ☐ NASOPHARYNGEAL
- ☐ ORAL MUCOSAL TRANSUDATE
- ☐ PLASMA
- ☐ SERUM
- ☐ STOOL
- ☐ SPUTUM
- ☐ THROAT
- ☐ URETHRA
- ☐ URINE
- ☐ WHOLE BLOOD
- ☐ FOOD-Specify:
- ☐ OTHER-Specify:

INDICATE TEST REQUESTED

HIV TESTING

- ☐ HIV Ag/Ab - Serum
- ☐ HIV AB - Oral Mucosal Transudate
- ☐ CD4/CD8 (EDTA whole blood)
- ☐ HIV-1 VIRAL LOAD (EDTA plasma)
- ☐ HIV-1 GENOTYPING (EDTA plasma)

OTHER

- ☐ AUTOCLAVE TEST STRIPS
- ☐ *LEGIONELLA* - DFA
- ☐ LYME DISEASE-DFA (Tick)

SEROLOGY

SERUM STATUS - If Applicable

- ☐ ACUTE ☐ CONVALESCENT
- ☐ ARBOVIRUS ENCEP PANEL (IgM) May-October Includes Eastern Equine, California, St. Louis and West Nile, CSF Only
- ☐ *BRUCELLA* SEROLOGY
- ☐ FUNGAL SEROLOGY COMPLEMENT FIXATION
- ☐ FUNGAL IMMUNODIFFUSION
- ☐ *FRANCISELLA* SEROLOGY
- ☐ *LEGIONELLA* - HA
- ☐ LYME DISEASE - EIA **Complete #4 (reverse)**
- ☐ MEASLES IgG
- ☐ MUMPS IgG
- ☐ RABIES AB SEROLOGY **Complete #3 (reverse)**
- ☐ RUBELLA IgG
- ☐ TETANUS TOXIN EIA
- ☐ VARICELLA ZOSTER IgG

SYPHILIS TESTING

- ☐ SYPHILIS (USR Test)
- ☐ SYPHILIS VDRL - CSF Only
- ☐ SYPHILIS DFA **Complete #2 (reverse)**
- ☐ SYPHILIS FTA - ABS DS*
- ☐ SYPHILIS TP-PA*
- ☐ SYPHILIS IgM WESTERN BLOT*

***Prior Approval Required**

MICROBIOLOGY

- ☐ AEROBIC ISOLATE ID **Complete #5 (reverse)**
- ☐ AFB SLIDE/CULTURE-CLINICAL SPECIMEN
- ☐ AFB IDENTIFICATION-ISOLATE ID
- ☐ *E. COLI* (SLT) TOXIN & SEROLOGY
- ☐ ENTERIC BACTERIAL CULTURE
- ☐ FOODBORNE ILLNESS-Stool or Food **Complete #6 (reverse)**
- ☐ FUNGAL IDENTIFICATION Isolate ID
- ☐ *LEGIONELLA* CULTURE
- ☐ *NEISSERIA GONORRHOEAE*-Isolation
- ☐ *NEISSERIA* - REFERRED CULTURE
- ☐ PARASITOLOGY - BLOOD
- ☐ PARASITOLOGY - STOOL
- ☐ PARASITOLOGY - WORM
- ☐ *PERTUSSIS* PCR
- ☐ *SALMONELLA* SEROTYPING-HUMAN
- ☐ *SHIGELLA* SEROTYPING

VIROLOGY

- ☐ ENTEROVIRUS PCR **Complete #6 (reverse)**
- ☐ RESPIRATORY PCR PANEL
- ☐ INFLUENZA (PCR/CULTURE) **Complete #7 (reverse)**
- ☐ VIRAL CULTURE

TESTS THAT REQUIRE MDHHS APPROVAL

- ☐ BACTERIAL TYPING-PFGE **Complete #6 (reverse)**
- ☐ BOTULISM TOXIN
- ☐ MUMPS - PCR
- ☐ MEASLES IgM
- ☐ MUMPS IgM
- ☐ NOROVIRUS PCR **Complete #6 (reverse)**
- ☐ *PERTUSSIS* CULTURE
- ☐ RUBELLA IgM
- ☐ *SALMONELLA* SEROTYPING NON-HUMAN
- ☐ TOXIC SHOCK TESTING
- ☐ AFB NUCLEIC ACID AMPLIFICATION
- ☐ OTHER _____

HEPATITIS TESTING

- ☐ HEPATITIS C ANTIBODY
- ☐ HEPATITIS B SURFACE ANTIGEN (HBsAg) **Complete #1 (reverse)**
- ☐ HEPATITIS B ANTIBODY (Anti-HBsAg)
- ☐ HEPATITIS A ANTIBODY (IgM)

INSTRUCTIONS FOR COMPLETION: Completely fill in the appropriate box. For example, upon completion the box should appear as ■, rather than ☒.

INDICATE TEST REASON

☐ Diagnosis ☐ Surveillance ☐ Outbreak (complete Section 6) ☐ Other (Specify)

1 FOR: HEPATITIS B REQUEST COMPLETE THIS SECTION

☐ Pregnancy (HBsAg) ☐ Exposure to someone with Hepatitis B?

2 FOR: SYPHILIS - DFA REQUEST COMPLETE THIS SECTION

Duration of Lesion ☐ Days ☐ Months ☐ Years Specify Site:

3 FOR: RABIES ANTIBODY SEROLOGY REQUEST COMPLETE THIS SECTION

Date of Last Rabies Vaccination	M	M	D	D	Y	Y	Y	Y

4 FOR: LYME BORRELIOSIS REQUEST COMPLETE THIS SECTION

Onset Date	M	M	D	D	Y	Y	Y	Y	State/County/Country of Exposure

EARLY DISEASE

☐ Erythema Migrans (5 cm at least in diameter) ☐ Symptoms (Example- Rash, Fever, Headache, Joint Pain)

LATE DISEASE

☐ Neurologic ☐ Cardiologic ☐ Rheumatologic

5 FOR: AEROBIC CULTURE REQUEST COMPLETE THIS SECTION

☐ Aerobe ☐ Microaerophile Gram ☐ Positive ☐ Negative ☐ Variable ☐ Rod ☐ Coccus ☐ Diplococcus

Bacterial Growth Char.: MacConkey ☐ Pos ☐ Neg Oxidase ☐ Pos ☐ Neg Catalase ☐ Pos ☐ Neg Dextrose ☐ Oxidation ☐ Fermentation

OTHER: _____

_____

_____

6 FOR: OUTBREAK INVESTIGATION COMPLETE THIS SECTION

Onset Date	M	M	D	D	Y	Y	Y	Y

Outbreak Identifier	
Organism Suspected (If Applicable)	
MDHHS Prior Approval: Name, Date or Code	

7 FOR: INFLUENZA TESTING REQUEST (PCR/CULTURE) COMPLETE THIS SECTION

Date/Type of Last Influenza Vaccination	M	M	D	D	Y	Y	Y	Y	TYPE ☐ Flu Mist ☐ Trivalent (Shot) ☐ Other _____

8 ADDITIONAL INFORMATION