Vaccinia/Variola/Pox Virus Test Requisition

(Test 2320)

Bureau of Laboratories Michigan Department of Community Health

PO Box 30035 3350 North Martin Luther King Jr. Blvd. Lansing Michigan 48909

Phone: 517-335-8059 (Laboratory Records) 517-335-8067 (Technical Information) Fax: 517-335-9871 Web: HTTP://www.Michigan.gov/mdch

Date Received at MDCH	MDCH Sample #

AGENCY - SUBMITTER INFORMATION	**ENTER EPIC CODE IF KNOWN >>>>>>**
Return Results to:	Phone (24/7)
	Fax

CONTACT PERSON/ATTENDING PHYSICIAN/PROVIDER:

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 | GENDER | Female | Male

RACE | BLACK | WHITE | MULTIRACIAL | AM. INDIAN, ESKIMO, OR ALEUT | ASIAN/PACIFIC ISLANDER | UNKNOWN

ANCESTRY | Hispanic | Non-Hispanic | Unknown | SOCIAL SECURITY #

DATE OF BIRTH M M D D Y Y Y Y | ONSET DATE M M D D Y Y Y Y

DESCRIPTION OF RASH: (check all that apply) VESICULAR MACULAR/PAPULAR PUSTULAR SCABS CENTRIFUGAL CENTRIPETAL

DEVELOPMENT OF RASH: (check all that apply) MULTIPLE STAGES SINGLE (SAME) STAGE LESIONS ON PALMS OF HANDS LESIONS ON SOLES OF FEET

PATIENT CONDITION: (check one) Toxic Non-Toxic

SPECIMEN INFORMATION

DATE COLLECTED M M D D Y Y Y Y | TIME COLLECTED A.M. P.M.

Submitter Sample Number	Quantity Submitted	**SOURCES** (Please Check All Types Submitted)
		Vesicle Aspirate
		Vesicle Roof
		Vesicle Scab
		Lesion Swab
		Biopsy Specimen – Specify Source_____
		Serum
		Whole Blood (EDTA)
		Throat Swab
		Autopsy – Specify Source _____
		Autopsy – Specify Source _____
		Autopsy – Specify Source _____