MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
MISSOURI STATE PUBLIC HEALTH LABORATORY

VIROLOGY TEST REQUEST

101 NORTH CHESTNUT STREET, PO BOX 570
JEFFERSON CITY, MO 65101
(573) 751-3334
http://health.mo.gov/lab/index.php

TEST(S) REQUESTED

SEROLOGY

- ☐ Arbovirus (WN & SLE) IgM
- ☐ Measles IgM
- ☐ Rubella IgM
- ☐ Arbovirus (Zika, Chikungunya, & Dengue) IgM
- ☐ Other: _____

MOLECULAR (PCR)

- ☐ Norovirus (Outbreak Location) _____
- ☐ Influenza
- ☐ Arbovirus (Zika, Chikungunya, & Dengue)
- ☐ Rash Testing (VZV/HSV)
- ☐ Other (Specify) _____

VIRUS ISOLATION

Culture Testing

- ☐ Influenza A&B
- ☐ Parainfluenza
- ☐ Adenovirus
- ☐ Enterovirus
- ☐ Cytomegalovirus (CMV)
- ☐ Varicella Zoster
- ☐ Mumps

ELISA Testing

- ☐ Adenovirus 1-41
- ☐ Rotavirus
- ☐ Respiratory Syncytial Virus (RSV)

Accession Number Barcode
(For SPHL use only)

HEPATITIS

Hepatitis A: (Diagnostic)

- ☐ anti-HAV IgM

Hepatitis B

- ☐ Pregnant (HBsAg)
- ☐ Prenatal Contact (anti-HBc)
- ☐ Infant Serology (anti-HBs)
- ☐ Refugee Screen (HBsAg)

SPECIMEN INFORMATION - Check appropriate specimen type and fill in requested information (ONLY one sample per form)

SPECIMEN TYPE (CHECK ONLY ONE)

☐ Serum	☐ Stool	☐ Lesion Roof/Scab	☐ Swab - Throat	☐ Resp. Wash/Aspirate
☐ Blood	☐ Urine	☐ Touch Prep. Slides	☐ Swab - Nasopharyngeal	☐ Wound/Tissue/Biopsy
☐ CSF	☐ Emesis (Vomit)	☐ Dry Swab	☐ Swab - Other: _____	☐ Other: _____

DATE COLLECTED (MM/DD/YYYY)	SPECIMEN ID

PATIENT INFORMATION

PATIENT ID	LAST NAME	FIRST NAME	M.I.

BIRTH DATE (MM/DD/YYYY)	ADDRESS

CITY	STATE	ZIP CODE	TELEPHONE NUMBER

GENDER ☐ Female ☐ Male

ETHNICITY ☐ Hispanic ☐ Non Hispanic ☐ Unknown

RACE ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Unknown

ATTENDING PHYSICIAN/CLINICIAN INFORMATION

PHYSICIAN LAST NAME	PHYSICIAN FIRST NAME

PHYSICIAN FACILITY NAME	PHYSICIAN TELEPHONE NUMBER

ADDRESS	CITY	STATE	ZIP CODE

SUBMITTER INFORMATION (RESULTS ARE RETURNED TO THIS ADDRESS)

SUBMITTER NUMBER	FACILITY NAME	OUTSIDE FACILITY NUMBER/NAME
2273	UNIVERSITY OF MO HOSPITALS & CLINICS	

ADDRESS	CITY	STATE	ZIP CODE
1 HOSPITAL DR 2W09	COLUMBIA	MO	65212

SUMBITTER CONTACT NAME	SUBMITTER TELEPHONE NUMBER

ADDITIONAL PATIENT INFORMATION

MEDICAL RECORDS/CHART	MEDICAID NUMBER/DCN	DATE OF ONSET (MM/DD/YYYY)

INFLUENZA VACCINATION ☐ Yes ☐ No DATE:

MMR VACCINATION DATE

SEROLOGY INFORMATION

ACUTE DATE	CONVALESCENT DATE

EPIDEMIOLOGICAL DATA

INCIDENCE ☐ Single Case ☐ Outbreak: _____