CDC Submission Form Instructions for Zika Virus Testing

Sample Submission Process

- Call Idaho Bureau of Laboratories (IBL) at 208-334-0589 to notify IBL when the shipment may arrive.
- Notify district or state epidemiologists using the contact information in the document **Idaho Public Health Guidance for Zika Virus Testing** at www.epi.idaho.gov.
- Collect and package at least 0.5 mL of serum (not whole blood) and/or 1.0 mL of cerebrospinal fluid (CSF). Keep the specimen cold (do not freeze). Send in an insulated container with ice packs.
- Complete **"CDC Form 50.34 for Idaho"**. Onset date (for symptomatic persons), pregnancy status, and travel history and dates must be included. **Samples with incomplete information on submittal forms will not be tested**.
- Send the sample with completed "CDC Form 50.34 for Idaho" to IBL (Attention: Virology Laboratory), as a Category B package.
- IBL will forward the sample to CDC. There is currently no charge for testing by CDC. Results will be reported to the submitter listed on the submittal form usually over 2 weeks after specimen receipt at CDC.

Page 1

Select the Specimen Origin to Begin the Form

HUMAN

CDC SPECIMEN SUBMISSION FORM: SPECIMENS OF HUMAN ORIGIN

LABORATORY EXAMINATION REQUESTED

Test order name:
Test order code:
Suspected agent:
Date sent to CDC: (MM/DD/YYYY)
At CDC, bring to the attention of:

PATIENT INFORMATION

Patient Name: Last / First / MI / Suffix
Birthdate: (MM/DD/YYYY) Age: Age units:
Sex:
Clinical diagnosis:
Date of onset: (MM/DD/YYYY)
Fatal: Date of death: (MM/DD/YYYY)

SPECIMEN INFORMATION

Specimen collected date: (MM/DD/YYYY) Time: (hh:mm)
Material submitted:
Specimen source (type):
Specimen source modifier:
Specimen source site:
Specimen source site modifier:
Collection method:
Treatment of specimen:
Transport medium/Specimen preservative:
Specimen handling:

CDC USE ONLY

CDC specimen identification label

Package ID#:
Delivered to Unit #:
Unit Specimen ID#:
Date received at CDC: ____ /____ /____
Date received at STAT: ____ /____ /____
Date received in testing lab: ____ /____ /____ Time: ____

Condition	STAT Laboratory	Testing Laboratory
Outer package		
Specimen container		
Specimen		

Barcode 1

STATE PHL / NEW YORK CITY DEPARTMENT OF HEALTH & MENTAL HYGIENE / FEDERAL AGENCY / INTERNATIONAL INSTITUTION / PEACE CORPS

Name: (Laboratory Director or designee)
Dr Ball Christopher L PhD (Prefix / Last / First / MI / Suffix / Degree)
Institution name: Idaho Bureau of Laboratories
Street address: 2220 Old Penitentiary Road (Line 1) (Line 2)
Boise 83712-8299 (City / ZIP/Postal code)
Idaho United States (State / Country)
Phone: 208 3342235 (Country code / Area code / Local number / Extension)
Fax: 208 3344067 statelab@dhw.idaho.gov (Country code / Area code / Local number / Institutional e-mail)
Point of contact: (Person to be contacted if there is a question regarding this order)
Prefix / Last / First / MI / Suffix / Degree
Patient ID Alternative Patient ID
Specimen ID Alternative Specimen ID

ORIGINAL SUBMITTER (Organization that originally submitted specimen for testing)

Name: (Laboratory Director or designee)
Prefix / Last / First / MI / Suffix / Degree
Institution name:
Street address: (Line 1) (Line 2)
City / ZIP/Postal code
State / Country
Phone: Country code / Area code / Local number / Extension
Fax: Country code / Area code / Local number / Institutional e-mail
Point of contact: (Person to be contacted if there is a question regarding this order)
Prefix / Last / First / MI / Suffix / Degree
Patient ID Alternative Patient ID
Specimen ID Alternative Specimen ID

INTERMEDIATE SUBMITTER (Complete if specimen is submitted to SPHL through an intermediate agency)

Name: (Laboratory Director or designee)
Prefix / Last / First / MI / Suffix / Degree
Institution name:
Street address: (Line 1) (Line 2)
City / ZIP/Postal code
State / Country
Phone: Country code / Area code / Local number / Extension
Fax: Country code / Area code / Local number / Institutional e-mail
Point of contact: (Person to be contacted if there is a question regarding this order)
Prefix / Last / First / MI / Suffix / Degree
Patient ID Alternative Patient ID
Specimen ID Alternative Specimen ID

CDC 50.34 HUMAN (Page 1) CDC SPECIMEN SUBMISSION FORM: SPECIMENS OF HUMAN ORIGIN Version 1.3, Expiration Date: 12/09/2016

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Select the Specimen Origin to Begin the Form

HUMAN

CDC SPECIMEN SUBMISSION FORM: SPECIMENS OF HUMAN ORIGIN

LABORATORY EXAMINATION REQUESTED

Test order name: Arbovirus Serology

Test order code: CDC-10282

Suspected agent:

Date sent to CDC: MM/DD/YYYY

At CDC, bring to the attention of:

Select "Arbovirus Serology" in drop down menu. Test order code will automatically populate.

Leave blank

IBL will fill out.

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DIVISION OF PUBLIC HEALTH

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Select the Specimen Origin to Begin the Form

HUMAN

CDC SPECIMEN SUBMISSION FORM: SPECIMENS OF HUMAN ORIGIN

LABORATORY EXAMINATION REQUESTED

Test order name:
Test order code:
Suspected agent:
Date sent to CDC:
At CDC, bring to the attention of:

STATE PHL / NEW YORK CITY DEPARTMENT OF HEALTH & MENTAL HYGIENE / FEDERAL AGENCY / INTERNATIONAL INSTITUTION / PEACE CORPS

Name: Dr Ball Christopher L PhD

Institution name: Idaho Bureau of Laboratories

Street address: 2220 Old Penitentiary Road

Boise 83712-8299

Idaho United States

Phone: 208 3342235

Fax: 208 3344067 statelab@dhw.idaho.gov

Point of contact:

Patient ID / Alternative Patient ID

Specimen ID / Alternative Specimen ID

SPECIMEN INFORMATION

Specimen collected date: Time:

ORIGINAL SUBMITTER (Organization that originally submitted specimen for testing)

PATIENT INFORMATION

Patient Name:

Smith	Jane		
Last	First	MI	Suffix

Birthdate: 01/01/1989 (MM/DD/YYYY) Age: 27 Age units: Year

Sex: Female

Clinical diagnosis: Rash

Date of onset: 02/20/2016 (MM/DD/YYYY)

Fatal: No Date of death: (MM/DD/YYYY)

Must complete this entire section, using appropriate selections from drop down boxes

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DIVISION OF PUBLIC HEALTH

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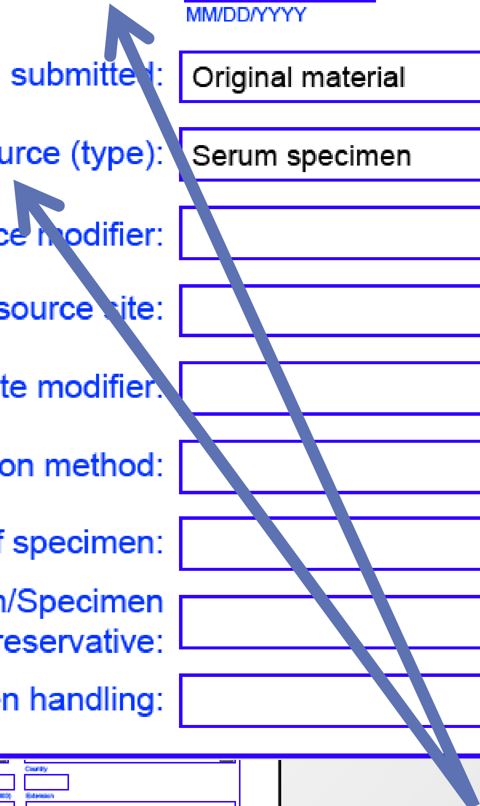
SPECIMEN INFORMATION

Field	Value
Specimen collected date:	02/24/2016 (MM/DD/YYYY)
Time:	(hh:mm:ss)
Material submitted:	Original material
Specimen source (type):	Serum specimen
Specimen source modifier:	
Specimen source site:	
Specimen source site modifier:	
Collection method:	
Treatment of specimen:	
Transport medium/Specimen preservative:	
Specimen handling:	



Must complete

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Select the Specimen Origin to Begin the Form

HUMAN

CDC SPECIMEN SUBMISSION FORM: SPECIMENS OF HUMAN ORIGIN

LABORATORY EXAMINATION REQUESTED

Test order name:

Test order code:

Suspected agent:

Date sent to CDC:

At CDC, bring to the attention of:

PATIENT INFORMATION

Patient Name:

STATE PHL / NEW YORK CITY DEPARTMENT OF HEALTH & MENTAL HYGIENE / FEDERAL AGENCY / INTERNATIONAL INSTITUTION / PEACE CORPS

Name: (Laboratory Director or designee)

Prefix	Last	First	MI	Suffix	Degree
Dr	Ball	Christopher	L		PhD

Institution name: Idaho Bureau of Laboratories

Street address: 2220 Old Penitentiary Road (Line 1)

Line 2

City: Boise — ZIP/Postal code: 83712-8299

State: Idaho — Country: United States

Phone: Country code: — Area code: 208 — Local number (e.g. 6390000): 3342235 — Extension:

Fax: Country code: — Area code: 208 — Local number (e.g. 6390000): 3344067 — Institutional e-mail: statelab@dhw.idaho.gov

Point of contact: (Person to be contacted if there is a question regarding this order)

Prefix	Last	First	MI	Suffix	Degree
	Getz	Kari			

Patient ID: — Alternative Patient ID:

Specimen ID: C160300001-001 — Alternative Specimen ID:

Much of this section is auto populated in the "CDC Form 50.34 for Idaho."

IBL will fill out.

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ORIGINAL SUBMITTER (Organization that originally submitted specimen for testing)

Name: (Laboratory Director or designee)

Prefix	Last	First	MI	Suffix	Degree
	Jones	Jon			

Institution name: Kooskia Clinic

Street address:
- Line 1: 111 Main Street
- Line 2:

City	ZIP/Postal code
Kooskia	83539

State	Country
Idaho	United States

Phone:

Country code	Area code	Local number (e.g. 6390000)	Extension
208	926	7000	

Fax:

Country code	Area code	Local number (e.g. 6390000)	Institutional e-mail

Point of contact: (Person to be contacted if there is a question regarding this order)

Prefix	Last	First	MI	Suffix	Degree
	James	Jesse			

Patient ID	123	Alternative Patient ID	
Specimen ID		Alternative Specimen ID	

Results will be sent to the original submitter.

Optional

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INTERMEDIATE SUBMITTER (Complete if specimen is submitted to SPHL through an intermediate agency)

Name: (Laboratory Director or designee)

Prefix	Last	First	MI	Suffix	Degree
	Flinstone	Fred			

Institution name: Idaho North Central District

Street address: 215 10th Street (Line 1)

Line 2:

City: Lewiston — ZIP/Postal code: 83501

State: Idaho — Country: United States

Phone: Country code 208 — Area code 799 — Local number (e.g. 6390000) 3100 — Extension

Fax: Country code — Area code — Local number (e.g. 6390000) — Institutional e-mail

Point of contact: (Person to be contacted if there is a question regarding this order)

Prefix	Last	First	MI	Suffix	Degree

Patient ID — Alternative Patient ID

Specimen ID — Alternative Specimen ID

Should contact local Public Health District and insert their information here for results to be sent

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CDC SPECIMEN SUBMISSION FORM: SPECIMENS OF HUMAN ORIGIN

Patient name: Last First | AND/OR Original Patient ID: | AND/OR SPHL Specimen ID:

PATIENT HISTORY

BRIEF CLINICAL SUMMARY (Include signs, symptoms, and underlying illnesses if known)

STATE OF ILLNESS

- Symptomatic
- Asymptomatic
- Acute
- Chronic
- Convalescent
- Recovered

TYPE OF INFECTION

- Upper respiratory
- Lower respiratory
- Cardiovascular
- Gastrointestinal
- Genital
- Urinary tract
- Other, specify
- Sepsis
- Central nervous system
- Skin/soft tissue
- Ocular
- Joint/bone
- Disseminated

THERAPEUTIC AGENT(S) DURING ILLNESS

Agent	Start date	End date
1.		
2.		
3.	MM/DD/YYYY	MM/DD/YYYY

EPIDEMIOLOGICAL DATA

EXTENT

- Isolated case
- Carrier
- Contact
- Outbreak
  - Family
  - Community
  - Healthcare-associated
  - Epidemic

TRAVEL HISTORY Travel: Dates of Travel: MM/DD/YYYY to MM/DD/YYYY

Travel: Foreign (Countries)

Travel: United States (States)

Foreign Residence (Country)

United States Residence (State)

Note: Additional states or countries of residence or travel should be entered in the Brief Clinical Summary field.

EXPOSURE HISTORY

Exposure:

- Animal — Type of Exposure:
  - Common name:
  - Scientific name:
- Arthropod — Type of Exposure:
  - Common name:
  - Scientific name:

RELEVANT IMMUNIZATION HISTORY

Immunization(s)	Date received
1.	
2.	
3.	
4.	MM/DD/YYYY

PREVIOUS LABORATORY RESULTS / COMMENTS (Or attach copy of test results or worksheet)

CDC USE ONLY

Barcode 2

Barcode 3

The Centers for Disease Control and Prevention (CDC), an agency of the Department of Health and Human Services, is authorized to collect this information, including the Social Security number (if applicable), under provisions of the Public Health Service Act, Section 301 (42 U.S.C. 241). Supplying the information is voluntary and there is no penalty for not providing it. The data will be used to increase understanding of disease patterns, develop prevention and control programs, and communicate new knowledge to the health community. Data will become part of CDC Privacy Act system 09-20-0106, "Specimen Handling for Testing and Related Data" and may be disclosed: to appropriate State or local public health departments and cooperating medical authorities to deal with conditions of public health significance; to private contractors assisting CDC in analyzing and refining records; to researchers under certain limited circumstances to conduct further investigations; to organizations to carry out audits and reviews on behalf of HHS; to the Department of Justice in the event of litigation, and to a congressional office assisting individuals in obtaining their records. An accounting of the disclosures that have been made by CDC will be made available to the subject individual upon request. Except for permissible disclosures expressly authorized by the Privacy Act, no other disclosure may be made without the subject individual's written consent.

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Include pregnancy status, type in "Zika testing," and add past history of other flavivirus infections (e.g., dengue, yellow fever, St. Louis encephalitis, Japanese encephalitis, or West Nile viruses).

CDC SPECIMEN SUBMISSION FORM: SPECIMENS OF HUMAN ORIGIN

PATIENT HISTORY

BRIEF CLINICAL SUMMARY (Include signs, symptoms, and underlying illnesses if known)

20 weeks pregnant. Traveled to Brazil February 1-14, 2016. Multiple mosquito bites. Rash on abdominal area.

STATE OF ILLNESS

- [x] Symptomatic
- [ ] Asymptomatic
- [ ] Acute
- [ ] Chronic
- [ ] Convalescent
- [ ] Recovered

TYPE OF INFECTION

- [ ] Upper respiratory
- [ ] Lower respiratory
- [ ] Cardiovascular
- [ ] Gastrointestinal
- [ ] Genital
- [ ] Urinary tract
- [ ] Other, specify
- [ ] Sepsis
- [ ] Central nervous system
- [x] Skin/soft tissue
- [ ] Ocular
- [ ] Joint/bone
- [ ] Disseminated

THERAPEUTIC AGENT(S) DURING ILLNESS

	Agent	Start date	End date
1.			
2.			
3.		MM/DD/YYYY	MM/DD/YYYY

Complete these sections

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CDC SPECIMEN SUBMISSION FORM: SPECIMENS OF HUMAN ORIGIN

Patient name: Last / First — AND/OR Original Patient ID: — AND/OR SPHL Specimen ID:

PATIENT HISTORY

BRIEF CLINICAL SUMMARY (Include signs, symptoms, and underlying illnesses if known)

STATE OF ILLNESS: Symptomatic, Asymptomatic, Acute, Chronic, Convalescent, Recovered

TYPE OF INFECTION: Upper respiratory, Lower respiratory, Cardiovascular, Gastrointestinal, Genital, Urinary tract, Other, specify; Sepsis, Central nervous system, Skin/soft tissue, Ocular, Joint/bone, Disseminated

THERAPEUTIC AGENT(S) DURING ILLNESS: Agent 1. 2. 3. — Start date — End date (MM/DD/YYYY)

Must include this information

Include yellow fever and Japanese encephalitis virus vaccination, if received.

EPIDEMIOLOGICAL DATA

EXTENT

- Isolated case
- Carrier
- Contact
- Outbreak
  - Family
  - Community
  - Healthcare-associated
  - Epidemic

TRAVEL HISTORY

Travel: Yes

Dates of Travel: 02/01/2016 to 02/14/2016 (MM/DD/YYYY)

Travel: Foreign (Countries): Brazil

Travel: United States (States)

Foreign Residence (Country)

United States Residence (State)

Note: Additional states or countries of residence or travel should be entered in the Brief Clinical Summary field.

EXPOSURE HISTORY

Exposure: Yes

- Animal — Type of Exposure: — Common name: — Scientific name:
- ✓ Arthropod — Type of Exposure: Bite — Common name: — Scientific name:

RELEVANT IMMUNIZATION HISTORY

Immunization(s)	Date received
1.	
2.	
3.	
4.	

MM/DD/YYYY

Specify exposure history

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Questions?

- Call your local Public Health District: http://healthandwelfare.idaho.gov/Health/HealthDistricts/tabid/97/Default.aspx
- Call IBL at 208-334-0589