

California Encephalitis Project

Viral and Rickettsial Disease Laboratory Specimen Submittal Form

**** THIS FORM MUST BE COMPLETED AND SENT WITH SPECIMENS ****

VERY IMPORTANT: PLEASE SPECIFY SPECIMEN TYPE & DATE OF COLLECTION

Patient's Last Name, First Name			Patient's mailing address (including Zip code)			Route to: [] SERO [] ISOL [] FA [] RAB [] EM		
Age <u>or</u> DOB:	Sex (circle): M F	Onset Date:	This section for Virus Laboratory use only. Date received by VRDL and State Accession Number					
Disease suspected <u>or</u> test requested: Encephalitis								
1 st	Specimen type and/or specimen source	Date Collected						
2 nd	Specimen type and/or specimen source	Date Collected						
3 rd	Specimen type and/or specimen source	Date Collected						
4 th	Specimen type and/or specimen source	Date Collected						
5 th	Specimen type and/or specimen source	Date Collected	1 st					
			2 nd					
			3 rd					
			4 th					
			5 th					
Facility Name and Address:			Carol Glaser, DVM, MD Acting Chief, Viral and Rickettsial Disease Laboratory Division of Communicable Diseases California Department of Health Services 850 Marina Bay Parkway Richmond, CA 94804				[] E IgM [] E PCR [] H PCR [] M PCR [] _____	

**Specimens should be placed on at least a cold pack and swabs should be in viral transport media. If CSF is frozen, please send on dry ice.
(All specimens may be sent on dry ice)**

Submitting Physician: _____ Phone# (_____) _____

Submitting Facility: _____ Fax# (_____) _____