

# Acute Flaccid Myelitis (AFM) – Specimen Submittal Form

## Viral and Rickettsial Disease Laboratory

Specimens should be placed on a cold pack or dry ice and swabs should be in viral transport media. If CSF is frozen, please send on dry ice.

### VERY IMPORTANT: PLEASE SPECIFY SPECIMEN TYPE & DATE OF COLLECTION

Patient's Last Name, First Name			Patient's County of Residence: _____
Has patient's resident county been notified about this case? <input type="checkbox"/> Yes <input type="checkbox"/> No			For questions about specimen shipping, please call (510) 307-8585.
DOB:	Sex (circle): M    F	Onset Date:	
<b>Note that physicians must obtain approval <u>prior to</u> submission of samples (see below contacts).</b>			<b>Section below for <u>Virus Laboratory use only</u>.</b> VRDL: Date received and VRDL Accession Number
<b>Respiratory Specimen</b>	Collection Date		
<input type="checkbox"/> Nasopharynx Swab	__/__/____		
<input type="checkbox"/> Throat Swab			
<input type="checkbox"/> Other, specify:			
<b>CSF (2-3 ccs)</b>	Collection Date		
	__/__/____		
<b>Acute serum (collected <i>prior</i> to IVIG)</b>	Collection Date		
	__/__/____		
<b>Convalescent serum</b>	Collection Date		
	__/__/____		
<b>Whole Blood</b>	Collection Date		
	__/__/____		
<b>Stool #1</b>	Collection Date		
	__/__/____		
<b>Stool #2</b>	Collection Date		
	__/__/____		
<b>Other, specify:</b>	Collection Date		
	__/__/____		
<b>Shippers Complete Mailing Address:</b>			<b>Ship samples to:</b> ATTN: Specimen Receiving Viral and Rickettsial Disease Laboratory California Department of Public Health 850 Marina Bay Parkway Richmond, CA 94804

#### **Requirements for sending samples to VRDL:**

- 1.) **Physician must obtain PRIOR approval to send samples for testing**  
 For approval, contact Shrimati Datta ([Shrimati.Datta@cdph.ca.gov](mailto:Shrimati.Datta@cdph.ca.gov); (510) 620-3747) or Kristen Wendorf ([Kristen.Wendorf@cdph.ca.gov](mailto:Kristen.Wendorf@cdph.ca.gov); (510) 620-3735)
- 2.) **Acute Flaccid Myelitis Case Summary and Specimen Submittal Form must be sent with complete sample set (when possible).**

Submitting Physician: \_\_\_\_\_ Phone# (\_\_\_\_\_) \_\_\_\_\_

Secure physician fax # for reporting laboratory results: (\_\_\_\_\_) \_\_\_\_\_

Submitting Facility: \_\_\_\_\_ Lab Fax # (\_\_\_\_\_) \_\_\_\_\_