

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.

Select the Specimen Origin to Begin the Form

HUMAN CDC SPECIMEN SUBMISSION FORM: SPECIMENS OF HUMAN ORIGIN

LABORATORY EXAMINATION REQUESTED: STATE PHL / NEW YORK CITY DEPARTMENT OF HEALTH & MENTAL HYGIENE /

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

PATIENT INFORMATION

Patient Name: _____
Birthdate: _____ Age: _____
Sex: _____
Clinical diagnosis: _____
Date of onset: _____
Fatal: _____ Date of death: _____

SPECIMEN INFORMATION

Specimen collected date: _____
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

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

Condition	STAT Laboratory	Tg
Outer package		
Specimen container		
Specimen		

Phone: _____
Fax: _____
Point of contact: _____
Patient ID: _____ Alternative Patient ID: _____
Specimen ID: _____ Alternative Specimen ID: _____

CDC 5034 HUMAN (Page 1) CDC SPECIMEN SUBMISSION FORM: SPECIMENS OF HUMAN ORIGIN Version 1.3, Expiration Date: 12/31/2016

SPECIMEN INFORMATION

Specimen collected date: **02/24/2016** Time: _____
MM/DD/YYYY hh:mm:ss

Material submitted: **Original material**

Specimen source (type): **Serum specimen**

Specimen source modifier: _____

Specimen source site: _____

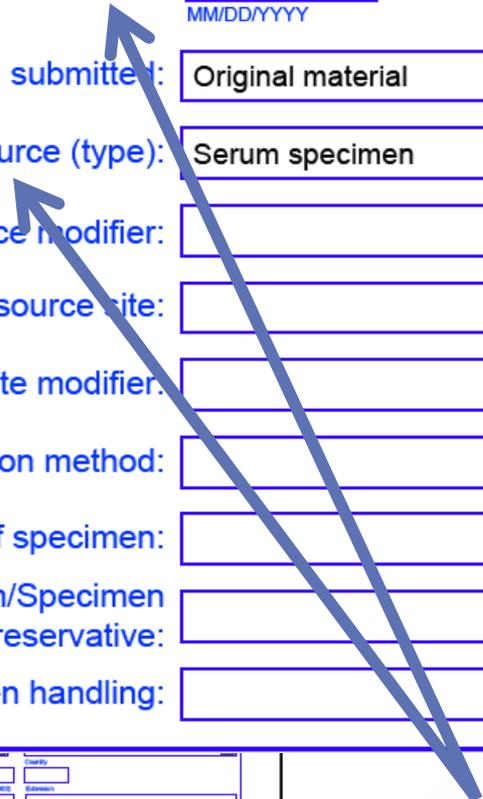
Specimen source site modifier: _____

Collection method: _____

Treatment of specimen: _____

Transport medium/Specimen preservative: _____

Specimen handling: _____



Must complete



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)
Dr [] Ball Christopher L [] PhD
Prefix Last First MI Suffix Degree
Institution name: Idaho Bureau of Laboratories
Street address: 2220 Old Penitentiary Road
Boise 83712-8299
City State ZIP/Postal code
United States
Phone: 208 3342235
Country code Area code Local number (e.g. 6390000) Extension
Fax: 208 3344067
Country code Area code Local number (e.g. 6390000) Institutional e-mail
statelab@dhw.idaho.gov
Point of contact: (Person to be contacted if there is a question regarding this order)
Getz Kari
Prefix Last First MI Suffix Degree
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.

Page 1

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

Name: (Laboratory Director or designee)

<input type="text" value="Flinstone"/>	<input type="text" value="Fred"/>	<input type="text"/>	<input type="text"/>
Prefix	Last	First	Degree

Institution name: Idaho North Central District

Street address: 215 10th Street

Line 1
Line 2

<input type="text" value="Lewiston"/>	<input type="text" value="83501"/>
City	ZIP/Postal code

<input type="text" value="Idaho"/>	<input type="text" value="United States"/>
State	Country

Phone:

Country code Area code Local number (e.g. 6390000) 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)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Prefix	Last	First	Degree

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Patient ID	Alternative Patient ID		

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Specimen ID	Alternative Specimen ID		

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

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



CDC SPECIMEN SUBMISSION FORM: SPECIMENS OF HUMAN ORIGIN															
Patient name: <input style="width: 150px;" type="text"/>		AND/OR Original Patient ID: <input style="width: 70px;" type="text"/>	AND/OR SPHL Specimen ID: <input style="width: 70px;" type="text"/>												
PATIENT HISTORY															
BRIEF CLINICAL SUMMARY (Include signs, symptoms, and underlying illnesses if known) <input style="width: 95%; height: 20px;" type="text"/>															
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PREVIOUS LABORATORY RESULTS / COMMENTS (Or attach copy of test results or worksheet) <input style="width: 95%; height: 20px;" type="text"/>															
CDC USE ONLY															
Barcode 2	Barcode 3														
<p>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. 261). 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 09-03-0100, "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.</p>															
CDC 50-34 HUMAN (Page 2)	CDC SPECIMEN SUBMISSION FORM: SPECIMENS OF HUMAN ORIGIN		Version 1.3, Expiration Date: 12/09/2016												



CDC SPECIMEN SUBMISSION FORM: SPECIMENS OF HUMAN ORIGIN

Patient name: [] 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

TYPE OF INFECTION

THERAPEUTIC AGENT(S) DURING ILLNESS

EPIDEMIOLOGICAL DATA

EXTENT

TRAVEL HISTORY

EXPOSURE HISTORY

RELEVANT IMMUNIZATION HISTORY

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).

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

TYPE OF INFECTION

THERAPEUTIC AGENT(S) DURING ILLNESS

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Complete these sections



Specify exposure history

CDC SPECIMEN SUBMISSION FORM: SPECIMENS OF HUMAN ORIGIN

Patient name: _____ 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 <input type="checkbox"/> Symptomatic <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input type="checkbox"/> Convalescent <input type="checkbox"/> Recovered	TYPE OF INFECTION <input type="checkbox"/> Upper respiratory <input type="checkbox"/> Lower respiratory <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Genital <input type="checkbox"/> Urinary tract <input type="checkbox"/> Other, specify _____	THERAPEUTIC AGENT(S) DURING ILLNESS Agent Start date End date 1. _____ 2. _____ 3. _____
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EPIDEMIOLOGICAL DATA

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

EXPOSURE HISTORY Exposure: Yes <input type="checkbox"/> Animal Type of Exposure: _____ Common name: _____ Scientific name: _____ <input checked="" type="checkbox"/> Arthropod Type of Exposure: Bite Common name: _____ Scientific name: _____	RELEVANT IMMUNIZATION HISTORY <table border="1"> <thead> <tr> <th>Immunization(s)</th> <th>Date received</th> </tr> </thead> <tbody> <tr> <td>1. _____</td> <td>_____</td> </tr> <tr> <td>2. _____</td> <td>_____</td> </tr> <tr> <td>3. _____</td> <td>_____</td> </tr> <tr> <td>4. _____</td> <td>_____</td> </tr> </tbody> </table>	Immunization(s)	Date received	1. _____	_____	2. _____	_____	3. _____	_____	4. _____	_____
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4. _____	_____										

Must include this information

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



Questions?

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

