REQUEST FORM FOR MICROBIOLOGY & VIROLOGY TESTING

Submitter information:
Clinic Name: _______________________________________________________
Address: __________________________________________________________
Phone: ____________________ Fax:_____________________________
Physician or submitter name: _______________________________________________

Patient information:
Last name: ___________________   First name: ________________________________
Address: ________________________________________________________________
Date of Birth: _______________  Sex:       Male    Female
Date of Onset of Symptoms: ____________ Symptoms: _________________________
Date of Collection: _______________       Time of Collection: ____________________
Type of specimen: (check the following)
  Stool       CSF
  Serum       Nasal swab
  Nasopharyngeal wash       Throat aspirate
  Urine       Wound
  Others_________________________________

Type of Test Requested :
  Enteric pathogens       Culture & Sensitivity
  Norovirus       West Nile Virus
  Influenza virus       Other (specify)____________________
  Influenza Rapid Test Results:_________________________________________

Specimen's storage: Hold all specimens at 4°C or on wet ice, but not frozen if delivery to the laboratory is within 48 hours of collection.

For H1N1 specimens, please check the applicable patient condition ( X)

<table>
<thead>
<tr>
<th>&lt; 5yrs old</th>
<th>&gt;65 years</th>
<th>Immunosuppression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic care patient</td>
<td>Pregnant</td>
<td>Nursing home resident</td>
</tr>
<tr>
<td>Adults and children who have chronic pulmonary, cardiovascular, hepatic, hematological, neurologic, neuromuscular, or metabolic disorder</td>
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</tbody>
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