Wyoming Public Health Laboratory

Combined Laboratories Facility
208 S. College Drive
Cheyenne, WY 82002
307.777.7431 FAX 307.777.6422

Wyoming Department of Health
Commit to your health.

LAB USE ONLY

Submitter Information:

Name _____

Address _____

_____

City/State/Zip _____

Telephone _____

Doctor _____

Patient Information or Patient ID Label (HIV sticker)

Last Name |___|___|___|___|___|___|___|___|___|___|___|___|_

First Name |___|___|___|___|___|___|___|___|___|___|___|___|_

Age_____ DOB _____ ☐ Female ☐ Male

Date Collected ____/____/____ Date of Onset ____/____/____

Convalescent Collection Date ____/____/____

Specimen Type

☐ Blood	☐ Throat	☐ Sputum	☐ Urine
☐ Serum	☐ Isolate	☐ Bronchial Wash	☐ Endocervical
☐ Oral Fluid	☐ Stool	☐ Tissue	☐ Urethral
☐ CSF	☐ Wound	☐ Nasopharyngeal	☐ Vaginal
☐ Other_____		☐ Food	☐ Rectal

Test Request

Immune Status
- ☐ Mumps
- ☐ Rubella
- ☐ Rubeola
- ☐ Varicella

Hepatitis
- ☐ Hepatitis B Surface Antibody
- ☐ Hepatitis B Surface Antigen
- ☐ Hepatitis B Core IgM
- ☐ Hepatitis C
- ☐ Hepatitis A Total
- ☐ Hepatitis A IgM

STD
- ☐ HIV 1 & 2 Plus O
- ☐ VDRL (CSF only)
- ☐ RPR
- ☐ FTA-ABS

CT/GC and West Nile Virus on Back

Culture/ID
- ☐ Rapid Strep Screen
- ☐ Bacterial Culture/ID_____
- ☐ Enteric Screen (FB)
- ☐ Salmonella Serotyping
- ☐ E. coli EHEC
- ☐ Ova & Parasites
- ☐ MRSA
- ☐ DRSP
- ☐ VRE
- ☐ TB Culture with Smear
- ☐ TB Identification

PCR
- ☐ Pertussis
- ☐ Norwalk Virus

Miscellaneous
- ☐ Hanta Virus
- ☐ Other_____

☐ CT/GC (Patient Information)

Patient's Residence	Race (check all that apply)	Risk History (check all that apply)
Zip Code ☐☐☐☐☐	☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander	☐ More than 1 partner in past 60 days ☐ New partner in past 60 days ☐ Positive for CT in past 12 months ☐ No risk history
Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Unknown		
Reason for Visit ☐ Symptomatic ☐ Exposed to STD in past 60 days ☐ IUD Insertion ☐ Patient Request ☐ Pregnancy Test Only Visit ☐ Client Meets Screening Criteria ☐ Postive CT-3 month rescreen	**Clinical Signs** (check all that apply) ☐ Cervical Friability ☐ Mucopus ☐ PID ☐ Urethritis ☐ None	**Treatment** Did you presumptively treat this patient for Chlamydia? ☐ Yes ☐ No **Specimen collected by:** _____

☐ West Nile Virus (Patient Information)

Date of onset of illness _____/_____/_____ Hospitalized? ☐Yes ☐ No Hospital Name: _____ Date of Admission _____/_____/_____	**Patient Symptoms** (check all that apply) ☐ Fever >38.0°C ☐ Pregnant ☐ Headache ☐ Breast Feeding ☐ Altered Mental Status ☐ CSF pleocytosis
Type of Specimens and Dates Collected Sample — Date Collected ☐ Acute Serum _____/_____/_____ ☐ Convalescent Serum _____/_____/_____ ☐ CSF _____/_____/_____	**Select illness most concurrent with symptoms** ☐ WEST NILE FEVER ☐ WNV MENINGITIS ☐ WNV ENCEPHALITIS ☐ WNV POLIOMYELITIS

Attending Physician Name	Telephone Number	FAX Number

CSF RESULTS:

Total WBC_____Differential_____%POLYS_____%LYMPHS PROTEIN_____mg%_____GLUCOSE_____mg%

LAB USE ONLY

CALL/REJECTION LOG

☐ ID discrepancies ☐ No test request
☐ No collection date ☐ No requisition form
☐ No demographics ☐ Expired collection device

Date contacted_____ Person contacted _____ Initials _____