Arbovirus Panel

All fields must be completed for tests to be processed. Each sample must be accompanied by a separate form.

For lab use only

Mississippi Public Health Laboratories
Main Lab - 570 East Woodrow Wilson
Jackson, Mississippi 39216
Phone 601-576-7582

Lawson Street Lab
3152 Lawson Street
Jackson, Mississippi 39213
Phone - 601-981-6158

Check all that apply:

- ❑ Encephalitis
- ❑ Meningitis
- ❑ Acute Flaccid Paralysis
- ❑ Fever
- ❑ Other

Sample type (Check one): ❑ Serum ❑ CSF

Patient History (Required):

Date of Symptom Onset ____/____/____

In the month prior to onset, did the person travel outside MS? ❑ Yes ❑ No

If yes, where? _____

Contact Information

Contact Name _____

Contact Phone _____

MSDH FORM 8021 (REVISED March 2009)

MR # _____ ID # _____

Name _____

Address _____

City/State _____

Zip Code _____

Sex ____ Race _____ DOB ___/___/___

SS # _____-_____-_____

Submitted by _____

Address _____

County/Clinic _____

Program _____

Date of collection _____/_____/_____

Place Barcode Label Here.

Arbovirus Panel, REQ 8021 Instructions

Purpose

This form is to provide submitters with a mechanism to request arbovirus screening assays and to provide a template for information required for test result interpretation.

Instructions

1. The form is divided into 3 sections. The left third is for laboratory use only and should be left blank.

2. The right section is for patient information. Please attach MSDH PIMS or non MSDH provider labels to both copies. If label with patient demographic information is unavailable, please complete each line with applicable information. All written information must be legible.

MR # - Enter patient's medical records number. **ID #** - Enter patient's PIMS number if available.

- **Name** - Enter the patient's LAST NAME, FIRST NAME, AND MIDDLE INITIAL in sequence. The spelling of the name on the laboratory slip and the specimen container/tube must be identical.
- **Street Address** - Enter the complete address where the patient currently lives. Post Office Box number should only be accepted if physical address is not available.
- **City** - Enter the name of the city in which the patient lives.
- **State** - Enter the state in which the patient lives.
- **Sex** - Enter "M" in space for male and "F" in space for female.
- **Race** - Enter the patient's race in the space provided (White, Asian, Black, Native American, Hawaiian/Pacific Islander, or other).
- **DOB** - Enter the Date of Birth (month, day, and year) of patient in the space provided.
- **Social Security Number** - Enter patient's nine digit Social Security Number in the spaces provided.
- **Submitted by** - Enter the name of the clinic/submitter in the space provided. We will not be able to send a report unless submitter information is complete.
- **Address** – Enter the address of the clinic/submitter.
- **County/Clinic** – Enter the name of the county for the clinic/submitter.
- **Program**- Enter name of program and activity code.
- **Date of collection** - Enter the date of specimen collection in MM/DD/YY format.

3. The middle box is for clinical and sample information.

Check all that apply- check all symptoms

Sample type- Check the appropriate box next to the type of specimen being submitted. Sometimes it is difficult for the lab to determine the origin of specimens by sight. The interpretation of this test is determined by the specimen type.

Patient history- information is **required.** Date of onset and travel history **must** be filled in. Without this information, testing will **NOT** be done. Travel history can be obtained by simply asking the patient or a family member. "Don't know" or "unknown" are **NOT** acceptable responses.

Contact information- Provide the name of the ordering physician including phone number.

Special notes:

Almost every blank on this form must be filled in for laboratory testing to be done. Tests for IgM antibodies to West Nile and St Louis Encephalitis are performed on all submissions. Tests for LaCrosse Encephalitis are performed for patients 25 years old and under. If the patient has traveled to an area where other viruses are known to occur, the sample is forwarded to the Division of Vector Borne Diseases at CDC, Ft Collins, CO to be tested against these viruses and this will be noted on the report. A final interpretation of test results is provided. The date of onset of symptoms, date of sample collection and type of sample are all needed to provide this interpretation. If confirmatory testing is indicated, the sample will be forwarded and this will be noted on the report. Final confirmatory testing reports will be forwarded to the submitter listed on the request form.

Office Mechanics and Filing

The top (white) copy will be used by the laboratory for specimen accessioning and will remain in the Immunology laboratory throughout the testing process. It will be used to enter data in the laboratory information management system (LIMS). This copy will be filed alphabetically by patient name in the testing division. Laboratory reports are kept for a minimum of 2 years as CLIA regulations require. The submitter will receive a chart copy of the report generated by the LIMS.

Retention Period

All clinical laboratory test records are retained for a minimum of 2 years from date of reporting.