"This form, when filled in, contains patient information that must be protected in accordance with the Health Insurance Portability Accountability Act."

Lab 275 (Rev 4/2021)

Kentucky Public Health
Prevent. Promote. Protect.

Viral Isolation and Immunology

KY Division of Laboratory Services
100 Sower Blvd Suite 204
Frankfort KY 40601
(502) 564-4446 FAX (502) 564-7019

Patient Information:

(Use label or fill in completely)

Name (Last, First, MI)

Social Security # Sex EO Birthdate (yyyy-mm-dd)

Home Address

City

State ZIP County

Send Reports to:

Submitter

Street Address / P O Box

City

State ZIP

Phone Fax

Physician (if other than Submitter)

Tests Requested

COVID-19	☐
Influenza	☐
Was patient prescreened for flu?	
Result of prescreening:	
Respiratory Panel	☐
Herpes/VZV	☐
Measles	☐
Mumps	☐
Norovirus	☐
Other	☐

Specimen Source / Date Collected

Throat Swab	☐	
NP Swab	☐	
OP Swab	☐	
Nasal Swab	☐	
Genital Swab	☐	
CSF	☐	
Stool	☐	
Serum	☐	
Other	☐	
Hospitilization		Yes ☐ No ☐
Pregnant		_____weeks

Testing approved?

COVID Sequencing

Yes ☐ No ☐

CLINICAL DATA

Purpose of request:

☐ diagnostic (**give onset**)

☐ immune status

☐ antibody status

☐ Deceased

Other _____

Date of Onset:

Symptoms:	YES	NO
Fever	☐	☐
Neurological	☐	☐
Headache	☐	☐
Respiratory	☐	☐
Gastrointestinal	☐	☐
Fatigue	☐	☐
Rash	☐	☐
Lesions	☐	☐

Other_____

Immunizations / Date

None ☐

MMR_____

Influenza_____

Varicella_____

COVID_____

Contacts / Recent Travel

Tick bite _____

Mosquito bite _____

Community _____

Other_____

Travel _____

**********DLS Laboratory Findings**********

Date Received	Laboratory #	Tech	Date Reported