



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
MISSOURI STATE PUBLIC HEALTH LABORATORY
VIROLOGY TEST REQUEST

101 NORTH CHESTNUT STREET, PO BOX 570
JEFFERSON CITY, MO 65101
(573) 751-3334
<http://health.mo.gov/lab/>

TEST(S) REQUESTED				Accession Number Barcode (For SPHL use only)	
SEROLOGY ☐ Arbovirus (WN & SLE) IgM ☐ Measles IgM / Rubella IgM ☐ SARS-CoV-2 IgG (COVID-19) ☐ Other (Specify): _____		HEPATITIS Hepatitis A (Diagnostic) ☐ Anti-HAV IgM Hepatitis B ☐ Pregnant (HBsAg, anti-HBc, anti-HBs) ☐ Prenatal Contact (anti-HBc) ☐ Infant Serology (anti-HBs & HBsAg) ☐ Refugee Screen (HBsAg) Hepatitis C ☐ Anti-HCV ☐ Anti-HCV, HBsAg, anti-HBc, anti-HBs		VIRUS ISOLATION Culture Testing ☐ Influenza A&B ☐ Parainfluenza ☐ Adenovirus ☐ Enterovirus ☐ Cytomegalovirus (CMV) ☐ Varicella Zoster	
SPECIMEN INFORMATION – Check appropriate specimen type and fill in requested information (ONLY one per form)					
SPECIMEN TYPE (CHECK ONLY ONE) ☐ Serum ☐ Stool ☐ Lesion Roof/Scab ☐ Swab - Anterior Nares ☐ Swab - Nasal ☐ Swab - Throat ☐ Plasma ☐ Blood ☐ Urine ☐ Dry Swab ☐ Swab - Buccal ☐ Swab - Dual Nasal/Oropharyngeal ☐ Resp. Wash/Aspirate ☐ Other ☐ CSF ☐ Emesis (Vomit) ☐ Wound/Tissue Biopsy ☐ Swab - Conjunctival ☐ Swab - Nasopharyngeal					
DATE COLLECTED (MM/DD/YYYY)			CLIENT REFERENCE		
PATIENT INFORMATION					
PATIENT ID		LAST NAME		FIRST NAME	
BIRTHDATE (MM/DD/YYYY)		ADDRESS			
CITY		STATE	ZIPCODE	TELEPHONE NUMBER	
GENDER ☐ Female ☐ Male		RACE ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Unknown			
ETHNICITY ☐ Hispanic ☐ Non Hispanic ☐ Unknown					
ATTENDING PHYSICIAN/CLINICIAN INFORMATION					
PHYSICIAN LAST NAME		PHYSICIAN FIRST NAME		NPI NUMBER (IF APPLICABLE)	
PHYSICIAN FACILITY NAME				PHYSICIAN TELEPHONE NUMBER	
ADDRESS		CITY		STATE	ZIPCODE
SUBMITTER INFORMATION (RESULTS ARE RETURNED TO THIS ADDRESS)					
FACILITY Children's Mercy					
ADDRESS 2401 Gillham Rd		CITY Kansas City		STATE MO	ZIPCODE 64108
SUBMITTER CONTACT NAME Send Outs Lab		SUBMITTER TELEPHONE NUMBER 816-234-3261		DATE TEST ORDERED (MM/DD/YYYY)	
ADDITIONAL PATIENT INFORMATION					
MEDICAL RECORDS/CHART		MEDICAID NUMBER/DCN		DATE OF ONSET (MM/DD/YYYY)	
INFLUENZA VACCINATION ☐ Yes ☐ No DATE: _____		MMR VACCINATION DATE		PATIENT COUNTY	
COVID VACCINATION ☐ Yes ☐ No DATE: _____		PATIENT PREGNANT ☐ Yes ☐ No ☐ Unknown			
SEROLOGY INFORMATION		EPIDEMIOLOGICAL DATA			
ACUTE DATE		CONVALESCENT DATE		INCIDENCE ☐ Single Case ☐ Outbreak: _____	

LAB 158 (04/2024)

