



Laboratories Administration

1770 Ashland Ave  
Baltimore, Maryland 21205

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**FEBRILE RASH (Low and Moderate Risk)**

Health Care Provider
Address
City _____ County _____
State _____ Zip Code _____
Contact Name
Phone# _____ Fax# _____
Test Request Authorized by:

**TYPE OR PRINT**

Patient's SS# (last 4 digits) \_\_\_\_\_ Case# \_\_\_\_\_

Patient \_\_\_\_\_ Lab No. \_\_\_\_\_

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_\_. Sex M F

Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Risk Category:** Low Risk Moderate Risk

For **Low Risk** and **Moderate Risk** testing, collect the following specimens:

**REMEMBER TO PLACE ONLY ONE LESION PER TUBE**

<i>tube id</i>	<i>collection device</i>	<i>specimen type needed</i>	<i>body site of collection (arm, chest, face, etc.)</i>	<i>description of site (vesicle, pustule, etc.)</i>
1	tube with transport media	swab of base of lesion		
2		swab of base of lesion		
3	long tube with swab and no liquid	swab of base of lesion		
4		swab of base of lesion		
5	small empty tube with O ring seal	crusUscab of lesion		
6		crusUscab of lesion		
7		crusUscab of lesion		
8		crusUscab of lesion		

Presumptive Clinical Diagnosis: Chickenpox Herpesvirus Smallpox

Smallpox vaccine (Vaccinia) Other: \_\_\_\_\_  
(specify)

Date of Onset: \_\_\_/\_\_\_/\_\_\_\_  
(Month / Day / Year)

Date Specimen Collected \_\_\_\_\_ Reported \_\_\_\_\_