



Guidance for Laboratory Testing for West Nile Virus

What form should be used to request testing?

- Complete the attached [BLUE](#) ADPH BCL Lab Slip BCL-140 08/02.
- Please ensure that patient's name, date of birth, date of collection, date of onset and the submitter's full contact information (name, address, and direct phone number) are completed. Also, please indicate if the sample was frozen prior to shipment.

What specimen should I collect?

- Serum specimens should be collected in gold-top or tiger-top tubes with serum separators.
- Allow blood to clot at room temperature prior to centrifugation.
- Refrigerate immediately after centrifugation.
- Serum may be shipped in the collection tube, or poured off into a separate sterile, screw-top collection tube.
- 1mL of serum is **required**, any additional serum is recommended.
- **Acute** serum is collected **3-10 days** after onset of symptoms.
- **Convalescent** serum is collected **2-3 weeks** after onset of symptoms.
- Specimens should be **collected and shipped on cold packs within 48hrs to the Bureau of Clinical Laboratories (BCL)**. If it will not be received within 48hrs, **freeze and hold at -20°C**.

How do I collect the specimen?

- Blood should be collected by venipuncture.

How do I package the specimen?

1. Place the sample into a leak proof container.
2. Use an appropriate insulated shipping container.
3. Be sure to ship with **frozen** cold packs.
4. Place a **frozen** cold pack on top of the specimen(s).
5. Place the completed lab slip in second, sealable plastic bag and place in the box.
6. Place the Styrofoam lid on the box, then close and seal the cardboard box.
7. Place the appropriate shipping labels on the box: address label and UN 3373 (biological substance) label if not already on the outer box.
8. Please indicate "WNV" on the outside of the box.

How do I ship the box?

1. You may ship the package on Monday through Thursday (specimen must be received within 48 hrs of collection) to:

Shipping Address
Bureau of Clinical Laboratories
8140 AUM Drive
Montgomery, AL 36117

2. You may take the box to your local county health department to be placed into the courier system (to be received within 48 hrs of collection). The specimen **MUST** be packaged as above before taking to the county health department.

Unsatisfactory Specimens

- Specimens received warm or hot due to no ice packs or melted ice packs.
- Specimens received in any other media besides gold/tiger tubes.
- Specimens received that were collected and stored longer than 48 hrs at 4°C.
- Specimens received without patient identification.
- Specimens where required CLIA demographics cannot be attained.

How Do I Get the Results?

- All WNV test results will be mailed directly to the healthcare provider.
- All specimens, regardless of result, are forwarded to the CDC (Ft. Collins branch) for further testing and confirmation. **This includes all CSF specimens, at this time.** The additional test results will be mailed when all testing is complete.
- Also, the CDC will not confirm a diagnosis without clinical correlation. Therefore, it is imperative the submission form be completed with as much information as possible.

Arboviral Testing Contact information

- For more information please go to www.adph.org/bcl, or call the Emerging Infectious Diseases department at 334-260-3429 or 334-260-3480.
- For information on WNV RT-PCR testing please contact EID.
- For information on other arboviral testing capabilities, including Dengue Virus, please contact EID.

Arboviral Testing <small>(Shaded area for laboratory use only)</small>		ALABAMA DEPARTMENT OF PUBLIC HEALTH BUREAU OF CLINICAL LABORATORIES <small>8140 ALM Drive, Montgomery, AL 36117-7110, Shipping P.O. BOX 244018, Montgomery, AL 36124-4018, Mail Telephone Number: (334) 260-3400</small>				Lab # _____	
Name: Last _____ First _____ MI _____		Date Received MM ____ DD ____ YY ____		CPT Code #1 _____		CPT Code #2 _____	
County Health Dept. CHR Number _____		Date Of Birth MM ____ DD ____ .YY ____		CPT Code #3 _____		CPT Code #4 _____	
Sex _____	Race _____	Date Collected MM ____ DD ____ YY ____		Specimen Submitted: <input type="checkbox"/> CSF <input type="checkbox"/> Acute Serum <input type="checkbox"/> Convalescent Serum <input type="checkbox"/> Other _____			
Medicaid Number _____		Test Requested: <input type="checkbox"/> WNV <input type="checkbox"/> EEE <input type="checkbox"/> SLE <input type="checkbox"/> LaCrosse <input type="checkbox"/> Other _____					
Social Security Number _____							

Date of Onset: ____/____/____ Patient Status: Ill Recovered Hospitalized Died

Clinical Diagnosis: _____

Clinical Symptoms: Fever (____ °F) Altered mental state Seizures
 Headache Stiff neck Muscle weakness
 Other neurologic signs _____ Other _____

CSF Findings: WBC count _____ Seg(%) _____ Lymphs (%) _____ Glucose _____ Protein _____

Vaccine History:
 Has the patient ever had? Military service Yellow fever vaccine Japanese encephalitis vaccine
 Dengue fever Flavivirus infection None of the above
(Check all that apply)

Travel History: In the 2 weeks prior to onset, did the patient

	Yes	No	Unknown	If yes, where?	If yes, dates:
Travel outside the United States?					
Travel outside Alabama?					

LABORATORY REPORT			
<small>(These tests are not FDA approved and are for research purposes only.)</small>			
Test(s)	Virus(es)	Results	P/N
<small>(Interpretations of results are on the reverse side.)</small>			
<input type="checkbox"/> Unsatisfactory, _____; Please submit _____			

Mail to: _____ Phone: (_____) _____ - _____

Analyst _____	Date MM ____ DD ____ YY ____
Reported: _____	

ADPH-F-BCL-140 (8/02) Provider Number _____

**ALABAMA DEPARTMENT OF PUBLIC HEALTH
BUREAU OF CLINICAL LABORATORIES**

8140 AUM Drive, Montgomery, AL 36117-7110, Shipping
P.O. BOX 244018, Montgomery, AL 36124-4018, Mail
Telephone Number: (334) 260-3400

Lab # _____

Arboviral Testing
(Shaded area for laboratory use only)

Name: Last **Doe**, First **John**, MI **A**

County Health Dept. CHR Number _____ Date Of Birth MM **01** DD **09** YY **52**

Sex _____ Race _____ Date Collected MM **06** DD **29** YY **12**

Medicaid Number _____

Social Security Number **4 4 4 4 4 4 4 4 4 4**

Date Received MM _____ DD _____ YY _____

CPT Code #1 _____ CPT Code #2 _____ CPT Code #3 _____ CPT Code #4 _____

Specimen Submitted: CSF Acute Serum
 Convalescent Serum Other _____

Test Requested: WNV EEE SLE
 LaCrosse Other _____

Date of Onset: **06/20/12** Patient Status: Ill Recovered Hospitalized Died

Clinical Diagnosis: **Severe headaches, myalgia, etc.**

Clinical Symptoms: Fever (**101** °F) **5 days** Altered mental state Seizures
 Headache Stiff neck Muscle weakness
 Other neurologic signs _____ Other _____

CSF Findings: WBC count _____ Seg(%) _____ Lymphs (%) _____ Glucose _____ Protein _____

Vaccine History: Has the patient ever had? Military service Yellow fever vaccine Japanese encephalitis vaccine
 Dengue fever Flavivirus infection None of the above

Travel History: In the 2 weeks prior to onset, did the patient

	Yes	No	Unknown	If yes, where?	If yes, dates:
Travel outside the United States?		X			
Travel outside Alabama?	X			New York, NY	6/10-15/2012

LABORATORY REPORT
(These tests are not FDA approved and are for research purposes only.)

Test(s)	Virus(es)	Results	P/N

(Interpretations of results are on the reverse side.)

Unsatisfactory, _____; Please submit _____

Mail to: **General Hospital of Alabama**
123 Anywhere St
Montgomery, AL 36117

Phone: (**334**) **555** - **5555**

Analyst	Date	MM	DD	YY
	Reported:			