# Arboviral Specimen Collection and Submission Instructions

The Pennsylvania Department of Health, Bureau of Laboratories (BOL) offers arboviral testing such as West Nile Virus (WNV) on Pennsylvania patients. Specimens that are positive early in the season or have indeterminate results will be sent to the Centers for Disease Control and Prevention (CDC) for confirmation. Testing is performed Monday through Friday.

**Acceptable Specimens for Arboviral testing:** At least 1mL of serum or cerebrospinal fluid (CSF)

**Specimen Collection:**

1. Collect 3-5 mL of blood in a serum-separator tube (SST). **DO NOT** collect blood in any tube containing anticoagulants or preservatives. Do Not send whole blood.
2. Label tube with patient's first & last name, date of birth (DOB) and collection date. Specimen label MUST match submission form, or specimen may be rejected.
3. Centrifuge blood collection specimen tube to separate the serum.
4. Refrigerate specimen at 2-8 °C until shipment.

**BOL Specimen Submission Form:**

1. Please include a submission form with each test request. Fill out the form with all the required fields marked with an *. Testing will not be initiated without the required fields. Use link below for the submission form.
2. Patient's information on the specimen submission form must match the information on the specimen container or else testing will **NOT** be performed.
3. Submitter name, complete address, and contact information, including both phone and fax number.
4. Label the specimen with patient's name, DOB, the specimen source, and the collection date.

PENNSYLVANIA DEPARTMENT OF HEALTH Arboviral Instruction and Submission Form

**Specimen Packaging and Storage Instructions:**

1. Place the tube in compartment of the biohazard bag and seal the bag. Place the paperwork in the outer pocket of the biohazard bag.
2. Store the specimen at 2 - 8°C until shipping and no longer than 7 days. If a delay in shipping is anticipated, freeze sera at –20°C or lower.
3. Ship as a Category B diagnostic specimen to the address on the submission form and include a return address.

**Shipping Instructions:**

1. Keep the specimen cold or frozen until it reaches the laboratory.
2. Ship the specimen with a cold pack if it is in cold temperature or on dry ice if it is frozen.
3. Do not ship specimens out on Fridays, weekends, day before a holiday or on holidays.

**Contact Hephzibah Tagaram Ph.D., Virology, Immunology, and Serology Supervisor, at 484-870-6380 or htagaram@pa.gov if you have questions.**

**References:**


1. Diagnostic Testing | West Nile Virus | CDC
2. West Nile Virus | West Nile Virus | CDC

pennsylvania
DEPARTMENT OF HEALTH

# Arbovirus Testing Specimen Submission Form

Please type directly into form and complete all required fields marked with an asterisk (*).

If you have questions on arbovirus testing please call Department of Health, Bureau of Epidemiology at 717-787-3350

**Patient Information:**

| | | | | | |
|---|---|---|---|---|---|
| Last name* | | First name* | | MI | |
| Date of birth* | | Gender* | | Race | | Ethnicity | |
| Street address* | | City* | | | |
| State* | | Zip* | | County* | | Patient ID | |

**Submitter Information:**

| | | | | | |
|---|---|---|---|---|---|
| Facility name* | | Ordering provider* if not a referring lab: | | | |
| Street address* | | City* | | State* | Zip* | |
| Telephone* | | Fax* | | Email | |

**Testing Requested***

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | West Nile virus | ☐ | Dengue | ☐ | EEE | ☐ | Powassan | ☐ | St Louis | ☐ | Other: |
| Test type* | ☐ | Serology | ☐ | PCR | | | | | | | |
| Specimen #1 source* | | Collection date* | | Onset date* | | | | | | | |
| Specimen #2 source | | Collection date | | | | | | | | | |

**Clinical Information:**

| | | | | | |
|---|---|---|---|---|---|
| Has the patient had any of the following symptoms*? (Specify below:) | | | ☐ Yes | ☐ No | |
| ☐ Fever (measured or subjective) | ☐ Joint pain | ☐ Altered mental status | | | |
| ☐ Headache | ☐ Stiff neck | ☐ Encephalitis | | | |
| ☐ Muscle weakness | ☐ Seizures | ☐ Meningitis | | | |
| ☐ Muscle pain | ☐ Rash | | | | |
| Other symptoms: | | | | | |
| Additional comments: | | | | | |

**Exposure History:** During the **30 days** before illness onset, did the patient

| | | | | | | |
|---|---|---|---|---|---|---|
| Travel outside of PA | ☐ Yes ☐ No | If yes, where? | | | | |
| Donate blood | ☐ Yes ☐ No | If yes, date? | | Donate organs | ☐ Yes | ☐ No |
| Receive blood | ☐ Yes ☐ No | If yes, date? | | Receive organs | ☐ Yes | ☐ No |

Submit specimens on cold pack(s) directly to the address below. Call the laboratory if you have any questions.
Print this form and send it along with the specimen.

Bureau of Laboratories
110 Pickering Way | Exton, PA 19341-1310 | 610.280.3464 | F 610.450.1932 | www.health.pa.gov/labs