



Case name (last, first) \_\_\_\_\_  
 Birth date \_\_\_/\_\_\_/\_\_\_ Age at symptom onset \_\_\_\_\_  Years  Months  
 Alternate name \_\_\_\_\_  
 Phone \_\_\_\_\_ Email \_\_\_\_\_  
 Address type  Home  Mailing  Other  Temporary  Work  
 Street address \_\_\_\_\_  
 City/State/Zip/County \_\_\_\_\_  
 Residence type (incl. Homeless) \_\_\_\_\_ WA resident  Yes  No

**Campylobacteriosis**

County \_\_\_\_\_

**ADMINISTRATIVE**

Investigator \_\_\_\_\_ LHM Case ID (optional) \_\_\_\_\_

LHM notification date \_\_\_/\_\_\_/\_\_\_

**Classification**

Classification pending  Confirmed  Investigation in progress  Not reportable  Probable  Ruled out  Suspect

Investigation status

Complete  Complete – not reportable to DOH  Unable to complete Reason \_\_\_\_\_  In progress

Dates: **Investigation start** \_\_\_/\_\_\_/\_\_\_ **Investigation complete** \_\_\_/\_\_\_/\_\_\_ **Record complete** \_\_\_/\_\_\_/\_\_\_ **Case complete** \_\_\_/\_\_\_/\_\_\_

**REPORT SOURCE**

Initial report source \_\_\_\_\_ LHM \_\_\_\_\_

Reporter organization \_\_\_\_\_

Reporter name \_\_\_\_\_ Reporter phone \_\_\_\_\_

All reporting sources (list all that apply) \_\_\_\_\_

**DEMOGRAPHICS**

Sex at birth:  Female  Male  Other  Unknown

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?

**Ethnicity**  Hispanic, Latino/a, Latinx  Non-Hispanic, Latino/a, Latinx  Patient declined to respond  Unknown

What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses):

**Race**  Amer Ind/AK Native (*specify:*  Amer Ind **and/or**  AK Native)  Asian  Black or African American  
 Native HI/Pacific Islander (*specify:*  Native HI **and/or**  Pacific Islander)  White  Patient declined to respond  Unk

Additional race information:

- Afghan  Afro-Caribbean  Arab  Asian Indian  Bamar/Burman/Burmese  Bangladeshi  Bhutanese
- Central American  Cham  Chicano/a or Chicanx  Chinese  Congolese  Cuban  Dominican  Egyptian
- Eritrean  Ethiopian  Fijian  Filipino  First Nations  Guamanian or Chamorro  Hmong/Mong
- Indigenous-Latino/a or Indigenous-Latinx  Indonesian  Iranian  Iraqi  Japanese  Jordanian  Karen
- Kenyan  Khmer/Cambodian  Korean  Kuwaiti  Lao  Lebanese  Malaysian  Marshallese  Mestizo
- Mexican/Mexican American  Middle Eastern  Mien  Moroccan  Nepalese  North African  Oromo
- Pakistani  Puerto Rican  Romanian/Rumanian  Russian  Samoan  Saudi Arabian  Somali
- South African  South American  Syrian  Taiwanese  Thai  Tongan  Ugandan  Ukrainian
- Vietnamese  Yemeni  Other: \_\_\_\_\_

What is your (your child's) preferred language? Check one:

- Amharic  Arabic  Balochi/Baluchi  Burmese  Cantonese  Chinese (unspecified)  Chamorro  Chuukese
- Dari  English  Farsi/Persian  Fijian  Filipino/Pilipino  French  German  Hindi  Hmong  Japanese
- Karen  Khmer/Cambodian  Kinyarwanda  Korean  Kosraean  Lao  Mandarin  Marshallese  Mixteco
- Nepali  Oromo  Panjabi/Punjabi  Pashto  Portuguese  Romanian/Rumanian  Russian  Samoan
- Sign languages  Somali  Spanish/Castilian  Swahili/Kiswahili  Tagalog  Tamil  Telugu  Thai  Tigrinya
- Ukrainian  Urdu  Vietnamese  Other language: \_\_\_\_\_  Patient declined to respond  Unknown

Interpreter needed  Yes  No  Unk

**EMPLOYMENT AND SCHOOL**

Employed  Yes  No  Unk Occupation \_\_\_\_\_ Industry \_\_\_\_\_  
 Employer \_\_\_\_\_ Work site \_\_\_\_\_ City \_\_\_\_\_

Student/Day care  Yes  No  Unk  
 Type of school  Preschool/day care  K-12  College  Graduate School  Vocational  Online  Other  
 School name \_\_\_\_\_ School address \_\_\_\_\_  
 City/State/County \_\_\_\_\_ Zip \_\_\_\_\_ Phone number \_\_\_\_\_ Teacher's name \_\_\_\_\_

**COMMUNICATIONS**

Primary HCP name \_\_\_\_\_ Phone \_\_\_\_\_  
 OK to talk to patient (If Later, provide date)  Yes  Later \_\_\_/\_\_\_/\_\_\_  Never  
 Date of interview attempt \_\_\_/\_\_\_/\_\_\_  Complete  Partial  Unable to reach  Patient could not be interviewed  
 Alternate contact:  Parent/Guardian  Spouse/Partner  Friend  Other \_\_\_\_\_  
 Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Outbreak related  Yes  No LHJ Cluster ID \_\_\_\_\_ Cluster Name \_\_\_\_\_

**CLINICAL INFORMATION**

Complainant ill  Yes  No  Unk Symptom Onset \_\_\_/\_\_\_/\_\_\_  Derived Diagnosis date \_\_\_/\_\_\_/\_\_\_  
 Illness duration \_\_\_\_\_  Days  Weeks  Months  Years Illness is still ongoing  Yes  No  Unk

**Clinical Features**

*Signs and Symptoms*

**Y N Unk**  
   **Diarrhea** (3 or more loose stools within a 24 hour period) Onset date \_\_\_/\_\_\_/\_\_\_  
   Bloody diarrhea  
   Abdominal pain or cramps  
   Nausea  
   Vomiting  
   Any fever, subjective or measured Temp measured?  Yes  No Highest measured temp \_\_\_\_\_°F  
   Focal infection

*Complications*

**Y N Unk**  
   Guillain-Barre syndrome  
   Bacteremia  
   Reactive arthritis

**Hospitalization**

**Y N Unk**  
   Hospitalized at least overnight for this illness Facility name \_\_\_\_\_  
 Hospital admission date \_\_\_/\_\_\_/\_\_\_ Discharge \_\_\_/\_\_\_/\_\_\_ HRN \_\_\_\_\_  
   Admitted to ICU Date admitted to ICU \_\_\_/\_\_\_/\_\_\_ Date discharged from ICU \_\_\_/\_\_\_/\_\_\_  
   Still hospitalized As of \_\_\_/\_\_\_/\_\_\_

**Y N Unk**  
   Died of this illness Death date \_\_\_/\_\_\_/\_\_\_ Please fill in the death date information on the Person Screen

**RISK AND RESPONSE (Ask about exposures 10 days before symptom onset)**

**Travel**

	Setting 1	Setting 2	Setting 3
Travel out of:	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____
Destination name	_____	_____	_____
Start and end dates	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___

**Risk and Exposure Information**

**Y N Unk**  
   Is case a recent foreign arrival (e.g., immigrant, refugee, adoptee, visitor) Country \_\_\_\_\_  
   Does the case know anyone else with similar symptoms or illness  
 Onset date, shared meals, relationship, etc. \_\_\_\_\_  
   Contact with lab confirmed case  
   Household  
   Sexual

**Y N Unk**

Other \_\_\_\_\_

Attends childcare or preschool Location/details \_\_\_\_\_

Contact with diapered or incontinent child or adult

**Food Exposure - Food exposure timeframe: 1-10 days prior to onset of illness**

**Sources of food IN home** - During exposure timeframe did you (your child) eat foods from:

- |  |   |
|--|---|
| <input type="checkbox"/> (1) Grocery stores or supermarkets  | <input type="checkbox"/> (7) Small markets/mini markets (convenience stores, gas stations, etc)                       |
| <input type="checkbox"/> (2) Home delivery grocery services (CSA, grocery delivery, Amazon Fresh, Peapod, etc) | <input type="checkbox"/> (8) Health food stores or co-ops   |
| <input type="checkbox"/> (3) Fish or meat specialty shops (butcher shop, etc)                                  | <input type="checkbox"/> (9) Ethnic specialty markets (Mexican, Asian, Indian)  |
| <input type="checkbox"/> (4) Warehouse stores (Costco, Sam's Club, etc.)                                       | <input type="checkbox"/> (10) Farmers markets, roadside stands, open-air markets, food purchased directly from a farm |
| <input type="checkbox"/> (5) Meal delivery services (Blue Apron, Meals on Wheels, Schwan's, NutriSystem, etc)  | <input type="checkbox"/> (11) Other _____   |
| <input type="checkbox"/> (6) Live animal market, custom slaughter facility                                     |   |

Type of Business (enter number next to choices above)	Business name	Address/location

**Sources of food outside home** - During exposure timeframe did you (your child) eat foods from:

- |  |  |
|--|--|
| <input type="checkbox"/> (1) Fast casual (Chipolte, Panera, etc)   | <input type="checkbox"/> (10) Chinese, Japanese, Vietnamese, other Asian-style               |
| <input type="checkbox"/> (2) Fast food (McDonald's, Burger King, Wendy's)  | <input type="checkbox"/> (11) All-you-can-eat buffet   |
| <input type="checkbox"/> (3) Sandwich shop, deli   | <input type="checkbox"/> (12) Breakfast, brunch, diner, or café                              |
| <input type="checkbox"/> (4) Jamaican, Cuban, or Caribbean   | <input type="checkbox"/> (13) Middle Eastern, Greek/Mediterranean, Arabic, Lebanese, African |
| <input type="checkbox"/> (5) Ready-to-eat prepared food from grocery or deli                                     | <input type="checkbox"/> (14) Any takeout from a restaurant                                  |
| <input type="checkbox"/> (6) An event where food was served (catered event, festival, church, or community meal) | <input type="checkbox"/> (15) Healthy restaurant (vegetarian, vegan, salad-based)            |
| <input type="checkbox"/> (7) Mexican, Salvadorian, other Hispanic/Latino-style                                   | <input type="checkbox"/> (16) Salad bar at a grocery store or restaurant                     |
| <input type="checkbox"/> (8) Food trucks, food stalls/stands   | <input type="checkbox"/> (17) Other _____  |
| <input type="checkbox"/> (9) School, hospital, senior center, or other institutional setting                     |  |

Type of Business (enter number next to choices above)	Restaurant/venue name	Date	Time of meal (Breakfast, Brunch, Lunch, Happy Hour, Dinner, Other)	Food ordered/eaten	Address/location
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		

**Y M N Unk**

Any food sampled (grocery, warehouse stores, food court, etc.) \_\_\_\_\_

**Consumed any of the following during exposure period****Meat****Y M N Unk**

- Poultry (e.g. chicken, turkey)
- Chicken, cooked whole or as cut chicken pieces/parts  
Place purchased \_\_\_\_\_ Type/variety/brand \_\_\_\_\_
- Ground chicken  
Place purchased \_\_\_\_\_ Type/variety/brand \_\_\_\_\_
- Breaded chicken products, such as chicken tenders/strips/nuggets \_\_\_\_\_
- Stuffed, frozen chicken products, such as chicken kiev or chicken cordon bleu \_\_\_\_\_
- Chicken liver / liver pate
- Turkey, cooked whole or as cut turkey pieces/parts
- Ground turkey
- Other poultry (e.g., duck, game hen, squab) \_\_\_\_\_

**Other processed meat products****Y M N Unk**

Other processed meat products (e.g., jerky, deli meats, sausage)

**Miscellaneous meat exposure****Y M N Unk**

- Were any of the previously indicated meats/poultry consumed rare, undercooked, or raw?  
 Goat  Lamb  Beef  Pork  Poultry  Wild game meat  Other \_\_\_\_\_
- Handled any raw meat, even if you did not eat it  
 Goat  Lamb  Beef  Pork  Poultry  Wild game meat  Other \_\_\_\_\_
- Poultry present in the household even if not eaten
- Ground beef present in the household even if not eaten

**Eggs and Dairy****Y M N Unk**

- Raw/unpasteurized milk (including cow, goat, sheep, etc.)  
Dairy animal type  Cow  Goat  Sheep  Other \_\_\_\_\_  
Type, variety or brand \_\_\_\_\_
- Any raw/unpasteurized milk left over
- Cheese made from raw/unpasteurized milk including homemade, farm-fresh, and door-to-door cheeses  
Type, variety or brand \_\_\_\_\_
- Any raw/unpasteurized cheese left over
- Other raw/unpasteurized dairy product (e.g., yogurt, kefir, ice cream)  
Type, variety or brand \_\_\_\_\_
- Any raw/unpasteurized dairy product left over

**Water Exposure****Y N Unk****Describe**

- Source of drinking water known
- Bottled water \_\_\_\_\_
- Public water system \_\_\_\_\_
- Individual well \_\_\_\_\_
- Shared well \_\_\_\_\_
- Other \_\_\_\_\_
- Untreated/unchlorinated water (e.g., surface, well, lake, stream, spring) \_\_\_\_\_
- Any recreational water exposure (e.g., lake, river, pool, waterpark) \_\_\_\_\_  
Water site name/location \_\_\_\_\_  
Treatment  Treated  Untreated  Unk  
Type  Lake  River  Pool/hot tub  Wading pool  Fountain  Waterpark  
 Splash pad/water playground  Other

**Animal Exposure****Y N Unk**

Any contact with pet animals at home or elsewhere

**Y N Unk**

- Cats or kittens
- Dogs or puppies
- Pet birds such as parakeets, parrots, cockatiels \_\_\_\_\_
- Any sick pets \_\_\_\_\_
- Any new household pets in the last month \_\_\_\_\_

**Y N Unk**

- Any contact with pet food or treats
- Raw pet food Type/variety/brand \_\_\_\_\_
- Pet treats or chews (pig ears, pizzles, rawhide, hooves, etc.) Type/variety/brand \_\_\_\_\_
- Prepackaged pet food (canned or dry) Type/variety/brand \_\_\_\_\_

**Y N Unk**

- Any contact with farm animals, including chickens or ducks
- Cows or calves
- Baby chicks, ducklings or baby poultry \_\_\_\_\_
- Adult chickens, turkeys, or other adult poultry \_\_\_\_\_
- Other animal contact \_\_\_\_\_

*Animal Settings*

**Y N Unk**

- Live on a farm or other setting that has farm animals \_\_\_\_\_
- Household member works with animals \_\_\_\_\_
- Work with animals or animal products (e.g., research, farming, veterinary medicine, animal slaughter)

*Exposure to any of the following facilities/settings even if no direct animal contact*

	<b>Y N Unk</b>	<b>Describe</b>	<b>Type of exposure</b>
Research facility	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
Slaughterhouse	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
Veterinary facility	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit

*Visited or worked on any of the following settings even if no direct animal contact*

	<b>Y N Unk</b>	<b>Location, animals, etc.</b>	<b>Type of exposure</b>
Petting zoo	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
Zoo	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
Dairy farm	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
Other farm contact	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
Agricultural 'Farm and Feed' store	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
County/state fairs, 4-H events, or similar events where animals are present	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
Pet store or other places where animals are sold or adopted	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
Attended any school events, birthday parties, or similar events with animals/pets	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
Other setting with animals Describe _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit

**Exposure and Transmission Summary**

**Y N Unk**

- Epi-linked to a confirmed or probable case**
- Outbreak related**
- Likely geographic region of exposure  In Washington – county \_\_\_\_\_  Other state \_\_\_\_\_  
 Not in US - country \_\_\_\_\_  Unk
- International travel related  During entire exposure period  During part of exposure period  No international travel
- Suspected exposure type  Foodborne  Waterborne  Animal related  Unk  Other \_\_\_\_\_
- Describe \_\_\_\_\_

- Suspected exposure setting  Day care/Childcare  School (not college)  Doctor's office  Hospital ward  Hospital ER  
 Hospital outpatient facility  Home  Work  College  Military  Correctional facility  Place of worship  
 Laboratory  Long term care facility  Homeless/shelter  International travel  Out of state travel  Transit  
 Social event  Large public gathering  Restaurant  Hotel/motel/hostel  Other \_\_\_\_\_

Describe \_\_\_\_\_

Exposure summary

- Suspected transmission type (check all that apply)  Foodborne  Waterborne  Animal related  Unk  
 Other \_\_\_\_\_

Describe \_\_\_\_\_

- Suspected transmission setting (check all that apply)  Day care/Childcare  School (not college)  Doctor's office  
 Hospital ward  Hospital ER  Hospital outpatient facility  Home  Work  College  Military  
 Correctional facility  Place of worship  Laboratory  Long term care facility  Homeless/shelter  
 International travel  Out of state travel  Transit  Social event  Large public gathering  Restaurant  
 Hotel/motel/hostel  Other \_\_\_\_\_

Describe \_\_\_\_\_

**Public Health Issues**

**Y N Unk**

- Household member or close contact in sensitive occupation or setting (HCW, childcare, food)  
   Does patient have contact with a day care  
   Non-occupational food handling (e.g., potlucks, receptions) during contagious period  
   Employed as a food handler  
   Employed as a health care worker  
   Employed in childcare or preschool

*If needed, enter detailed information in the Transmission Tracking Question Package*

**Public Health Interventions/Actions**

**Y N Unk**

- Exclude case from sensitive occupations (HCW, food, childcare) or situations (childcare) until diarrhea ceases  
   Hygiene education provided  
   Childcare inspection  
   Investigation of raw milk dairy  
   Work or childcare restriction for household member  
   Restaurant inspection Restaurant name/location \_\_\_\_\_  
   Commercial product implicated  
   Initiate trace-back investigation  
   Letter sent Date \_\_\_/\_\_\_/\_\_\_ Batch date \_\_\_/\_\_\_/\_\_\_  
   Any other public health action \_\_\_\_\_

**TRANSMISSION TRACKING**

Visited, attended, employed, or volunteered at any public settings while contagious  Yes  No  Unk

Settings and details (check all that apply)

- Daycare  School  Airport  Hotel/Motel/Hostel  Transit  Healthcare  Home  Work  College  
 Military  Correctional facility  Place of worship  International travel  Out of state travel  LTCF  
 Homeless/shelter  Social event  Large public gathering  Restaurant  Other

	Setting 1	Setting 2	Setting 3	Setting 4
Setting Type (as checked above)				
Facility Name				
Start Date	___/___/___	___/___/___	___/___/___	___/___/___
End Date	___/___/___	___/___/___	___/___/___	___/___/___
Time of Arrival				
Time of Departure				
Number of people potentially exposed				
Details (hotel room #, HC type, transit info, etc.)				
Contact information available for setting (who will manage exposures or disease control for setting)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
Is a list of contacts known?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk

*If list of contacts is known, please fill out contact tracing form Question Package*

**TREATMENT****Y N Unk**   Did patient receive prophylaxis/treatment

Specify antibiotic \_\_\_\_\_

Treatment start date \_\_\_/\_\_\_/\_\_\_ Treatment end date \_\_\_/\_\_\_/\_\_\_ Number of days actually taken \_\_\_\_\_

**NOTES****LAB RESULTS**Lab report information**Lab report reviewed – LHJ** 

WDRS user-entered lab report note

Submitter \_\_\_\_\_

Performing lab for entire report \_\_\_\_\_

Referring lab \_\_\_\_\_

Specimen**Specimen identifier/accession number** \_\_\_\_\_**Specimen collection date** \_\_\_/\_\_\_/\_\_\_ **Specimen received date** \_\_\_/\_\_\_/\_\_\_**WDRS specimen type** \_\_\_\_\_

WDRS specimen source site \_\_\_\_\_

WDRS specimen reject reason \_\_\_\_\_

Test performed and result**WDRS test performed** \_\_\_\_\_**WDRS test result, coded** \_\_\_\_\_

WDRS test result, comparator \_\_\_\_\_

**WDRS result, numeric only** (enter only if given, including as necessary **Comparator** and **Unit of measure**) \_\_\_\_\_

WDRS unit of measure \_\_\_\_\_

Test method \_\_\_\_\_

WDRS interpretation code \_\_\_\_\_

Test result – Other, specify \_\_\_\_\_

**WDRS result summary**  Positive  Negative  Indeterminate  Equivocal  Test not performed  PendingTest result status  Final results; Can only be changed with a corrected result Preliminary results Record coming over is a correction and thus replaces a final result Results cannot be obtained for this observation Specimen in lab; results pending

Result date \_\_\_/\_\_\_/\_\_\_

**Upload document**Ordering Provider

WDRS ordering provider \_\_\_\_\_

Ordering facility

WDRS ordering facility name \_\_\_\_\_