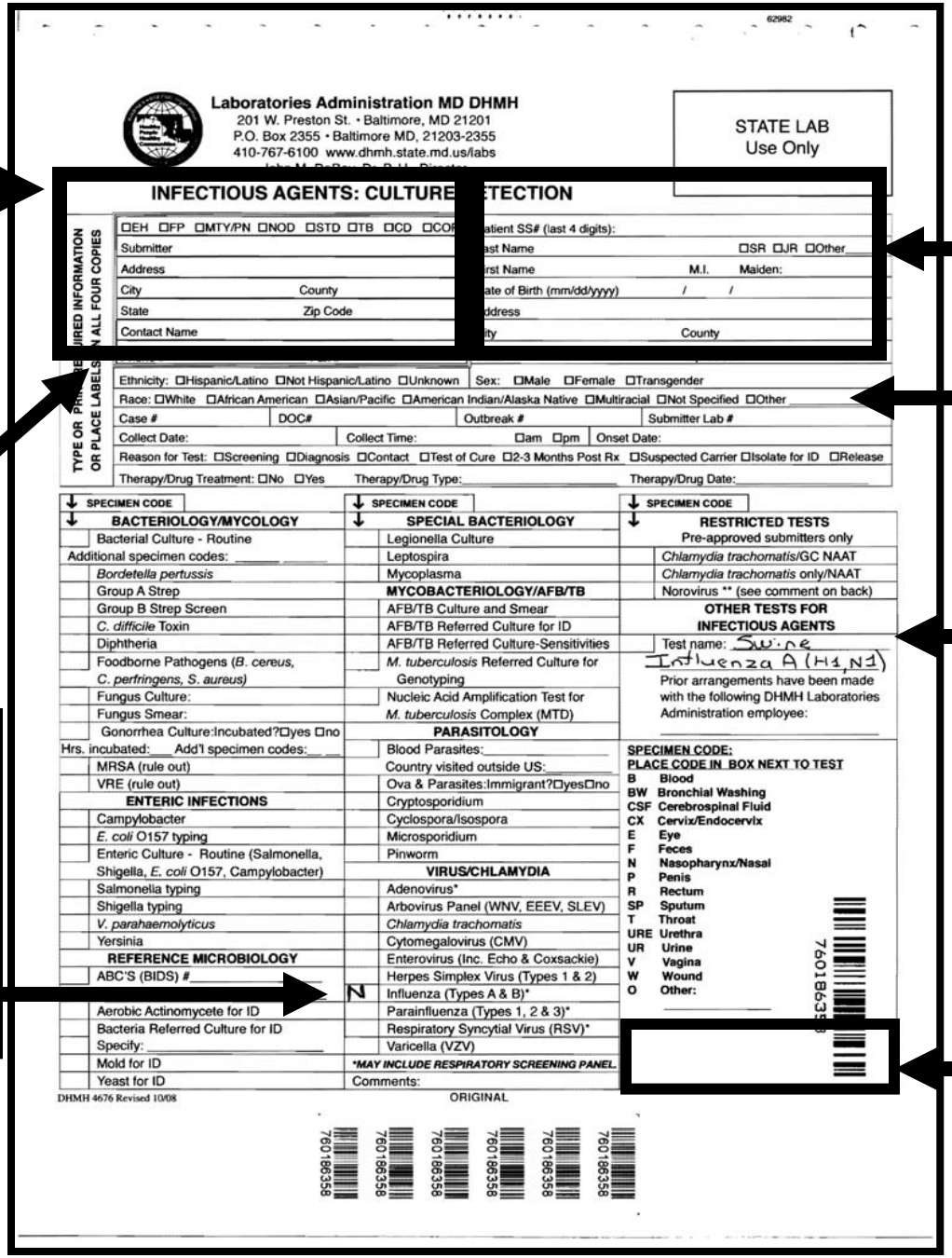
Laboratory Test Request Slip (Infectious Agents: Culture/Detection) Instructions

1. Please complete the submitter box. write the contact information for the LHD in the submitter box, as well as the name of the physician under the contact name.

2. Please include the LHD phone number.

4. Indicate specimen source as N (nasopharyngeal) or T (throat) or Others (please specify).
5. Indicate "Influenza Types A&B" as test requested.



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STATE LAB Use Only

INFECTIOUS AGENTS: CULTURE ETECTION

☐EH ☐FP ☐MTY/PN ☐NOD ☐STD ☐TB ☐CD ☐COR

Submitter
Address
City County
State Zip Code
Contact Name

TYPE OR PRINT REQUIRED INFORMATION OR PLACE LABEL IN ALL FOUR COPIES

atient SS# (last 4 digits):
ast Name ☐SR ☐JR ☐Other
rst Name M.I. Maiden:
ate of Birth (mm/dd/yyyy) / /
ddress
ity County

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Unknown Sex: ☐Male ☐Female ☐Transgender
Race: ☐White ☐African American ☐Asian/Pacific ☐American Indian/Alaska Native ☐Multiracial ☐Not Specified ☐Other
Case # DOC# Outbreak # Submitter Lab #
Collect Date: Collect Time: ☐am ☐pm Onset Date:
Reason for Test: ☐Screening ☐Diagnosis ☐Contact ☐Test of Cure ☐2-3 Months Post Rx ☐Suspected Carrier ☐Isolate for ID ☐Release
Therapy/Drug Treatment: ☐No ☐Yes Therapy/Drug Type: Therapy/Drug Date:

SPECIMEN CODE	BACTERIOLOGY/MYCOLOGY
	Bacterial Culture - Routine
	Additional specimen codes:
	Bordetella pertussis
	Group A Strep
	Group B Strep Screen
	C. difficile Toxin
	Diphtheria
	Foodborne Pathogens (*B. cereus, C. perfringens, S. aureus*)
	Fungus Culture:
	Fungus Smear:
	Gonorrhea Culture:Incubated?☐yes ☐no
	Hrs. incubated: Add'l specimen codes:
	MRSA (rule out)
	VRE (rule out)
	ENTERIC INFECTIONS
	Campylobacter
	E. coli O157 typing
	Enteric Culture - Routine (Salmonella, Shigella, *E. coli* O157, Campylobacter)
	Salmonella typing
	Shigella typing
	V. parahaemolyticus
	Yersinia
	REFERENCE MICROBIOLOGY
	ABC'S (BIDS) #
	Aerobic Actinomycete for ID
	Bacteria Referred Culture for ID
	Specify:
	Mold for ID
	Yeast for ID

SPECIMEN CODE	SPECIAL BACTERIOLOGY
	Legionella Culture
	Leptospira
	Mycoplasma
	MYCOBACTERIOLOGY/AFB/TB
	AFB/TB Culture and Smear
	AFB/TB Referred Culture for ID
	AFB/TB Referred Culture-Sensitivities
	M. tuberculosis Referred Culture for Genotyping
	Nucleic Acid Amplification Test for *M. tuberculosis* Complex (MTD)
	PARASITOLOGY
	Blood Parasites:
	Country visited outside US:
	Ova & Parasites:Immigrant?☐yes☐no
	Cryptosporidium
	Cyclospora/Isospora
	Microsporidium
	Pinworm
	VIRUS/CHLAMYDIA
	Adenovirus*
	Arbovirus Panel (WNV, EEEV, SLEV)
	Chlamydia trachomatis
	Cytomegalovirus (CMV)
	Enterovirus (Inc. Echo & Coxsackie)
	Herpes Simplex Virus (Types 1 & 2)
N	Influenza (Types A & B)*
	Parainfluenza (Types 1, 2 & 3)*
	Respiratory Syncytial Virus (RSV)*
	Varicella (VZV)
	MAY INCLUDE RESPIRATORY SCREENING PANEL
	Comments:

SPECIMEN CODE	RESTRICTED TESTS
	Pre-approved submitters only
	Chlamydia trachomatis/GC NAAT
	Chlamydia trachomatis only/NAAT
	Norovirus ** (see comment on back)
	OTHER TESTS FOR INFECTIOUS AGENTS
	Test name: Swine Influenza A (H1,N1)
	Prior arrangements have been made with the following DHMH Laboratories Administration employee:

SPECIMEN CODE:
PLACE CODE IN BOX NEXT TO TEST

B Blood
BW Bronchial Washing
CSF Cerebrospinal Fluid
CX Cervix/Endocervix
E Eye
F Feces
N Nasopharynx/Nasal
P Penis
R Rectum
SP Sputum
T Throat
URE Urethra
UR Urine
V Vagina
W Wound
O Other:

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3. Include patient name, date of birth, and address.

9. Indicate date patient became ill (date of onset), and date this specimen was collected (collect date).

7. Indicate major symptoms(s), risk factors (i.e. travel exposure history, occupational, healthcare workers).
8. Indicate as "swine flu suspect."

6. If a rapid flu test was done, place result and vendor name of the test used.

May 2, 2009