Mandatory: Complete Health Care Provider Section

STATE LAB Use Only

Laboratories Administration MDH
1770 Ashland Ave • Baltimore, MD 21205
443-681-3800 http://health.maryland.gov/laboratories/
Robert A. Myers, Ph.D., Director

MARYLAND Department of Health

Mandatory: Fill in TRAB box.

Mandatory: Complete Patient Information Section.

INFECTIOUS AGENTS: CULTURE/DETECTION

TYPE OR PRINT REQUIRED INFORMATION OR PLACE LABELS ON BOTH COPIES

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

Heath Care Provider

Address

City County

State Zip Code

Contact Name:

Phone # Fax #

Test Request Authorized by:

Patient SS # (last 4 digits):

Last Name ☐ SR ☐ JR ☐ Other:

First Name M.I.

Date of Birth (mm/dd/yyyy) / /

Address

City County

State Zip Code

Complete Patient's Sex, Ethnicity, and Race Fields.

Sex: ☐ Male ☐ Female ☐ Transgender M to F ☐ Transgender F to M

Ethnicity: Hispanic or Latino Origin? ☐Yes ☐ No

Race: ☐ American Indian/Alaska Native ☐Asian ☐Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White

MRN/Case # DOC # Outbreak # Submitter Lab #

Date Collected:

Time Collected: ☐a.m. ☐ p.m.

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: ____/____/____

Mandatory: Collection date field must be completed in order for testing to be performed.

Mandatory: Complete specimen collection time field.

Mandatory: Complete Onset Date Field.

SPECIMEN SOURCE CODE

Group A Strep

Group B Strep Screen

C. difficile Toxin

Diphtheria

Foodborne Pathogens

(B. cereus, C. perfringens, S. aureus)

Gonorrhea Culture:

Incubated? ☐Yes ☐ No

Hours Incubated: _____

Add'l specimen Codes: _____ _____ _____

MRSA (rule out)

VRE (rule out)

ENTERIC INFECTIONS

Campylobacter

E. coli O157 typing/Shiga toxins

Enteric Culture - Routine

(Salmonella, Shigella, *E. coli* O157, Campylobacter)

Salmonella typing

Shigella typing

Vibrio

Yersinia

REFERENCE MICROBIOLOGY

ABC's (BIDS) # _____

Organism: _____

Bacteria Referred Culture for ID

Specify: _____

_____

SPECIMEN SOURCE CODE

MYCOBACTERIOLOGY/AFB/TB

M. tuberculosis referred Isolate for genotyping

Nuclear Acid Amplification Test for *M. tuberculosis* Complex (GeneXpert)

PARASITOLOGY

Blood Parasites:_____

Country visited outside US:

Ova & Parasites

Microsporidium

Pinworm

VIRUS/CHLAMYDIA

Adenovirus*

Chlamydia trachomatis culture

Cytomegalovirus (CMV)

Enterovirus (Includes Echo & Coxsackie)

Herpes Simplex Virus (Types 1 & 2)

Influenza (Types A & B)* Rapid Flu Test:

Type: _____

I No

Parainfluenza (Types 1, 2 & 3)*

Respiratory Syncytial Virus (RSV)*

VARICELLA (VZV)

*MAY INCLUDE RESPIRATORY SCREENING PANEL

Comments:

Mandatory: Order Test Using Specimen Code and Indicate Ebola PCR

Mandatory: Use Specimen Source Code List to Indicate Specimen Type Submitted

SPECIMEN SOURCE CODE

SPECIAL BACTERIOLOGY

L

L

Mycoplasma (Outbreak Investigation Only)

RESTRICTED TESTS

Pre-approved submitters only

Chlamydia trachomatis/GC NAAT

**Norovirus (See comment on reverse)

QuantiFERON

Incubation: Time began: _____a.m./p.m.

Time ended: _____a.m./p.m.

OTHER TESTS FOR INFECTIOUS AGENTS

B Test Name: Ebola Virus PCR

Prior arrangements have been made with the following MDH Labs Administration employee:

Note Name of Lab Personnel or Epidemiologist Here

SPECIMEN SOURCE CODES

PLACE CODE IN BOX NEXT TO TEST

B	Blood	SP	Sputum
BW	Bronchial Washing	T	Throat
CSF	Cerebrospinal Fluid	URE	Urethra
CX	Cervix/Endocervix	UFV	Urine (1st Void)
E	Eye	UCC	Urine (Clean Catch)
F	Feces	V	Vagina
N	Nasopharynx/Nasal	W	Wound
P	Penis	O	Other: _____
R	Rectum		