MARYLAND
Department of Health

Maryland Department of Health Laboratories Administration
INSTRUCTIONS FOR ISOLATE SUBMISSION FOR ARLN AMR REFERENCE TESTING

Isolates must meet one of the following criteria when submitting to the ARLN Regional Laboratory

- **Unique gene found in PCR (NDM, OXA-48, IMP, VIM)**
- **Phenotypic and Genotypic Result Discrepancy**
- **Outbreak of CRE/CRPA and further characterization warranted**

PLEASE DO NOT SEND YOUR CRE/CRPA STATE WIDE SURVEILLANCE SPECIMENS TO THE REGIONAL LABORATORY—EACH STATE JURISDICTIONAL PUBLIC HEALTH LABORATORY SHOULD BE PERFORMING AST AND PCR TESTING FOR THEIR RESPECTIVE SURVEILLANCE SPECIMENS

Notify the MD ARLN Laboratory at mdphl.arln@maryland.gov when sending isolates for Reference Testing – please include the expected receipt date & FedEx tracking number.

FOLLOW THE STEP BY STEP INSTRUCTIONS MENTIONED BELOW:

1. Prepare an agar slant (e.g. TSA, blood agar, etc.) with the isolate to be submitted for AMR reference testing labeled with the appropriate patient identifiers. At least two patient identifiers (such as patient name and date of birth) are required on the specimen under CLIA regulations. Seal the slant or the plate with a piece of parafilm or tape.

2. Go to health.maryland.gov/laboratories/Pages/Home.aspx and click on the Infectious Agents Culture Detection link which will bring up our fillable lab test ordering form which can then be printed after completing or print a scanned copy of the form which can be filled-out manually. Complete the top portion of the form to include all submitting entity and patient demographic information. Include the name of the Healthcare provider who can legally order the test(s) in "Test Request Authorized by" field if these results are to be returned and placed into the patient's medical record. On the right side, under the section Other Tests for Infectious Agents, or under Reference Microbiology on bottom left side, enter specimen source code in the box and write the name of test as CRE Testing or ARLN Reference testing; also include the name of the isolate species. Attach the provided star shaped large colored "ARLN Reference Test" sticker to the form (See Page 3 for further details). This sticker will help ensure that the specimen/isolate is directed to ARLN Lab for priority reference testing. Without this sticker, the specimen will be processed as a surveillance specimen/isolate, which could be batch tested. More stickers when exhausted can be obtained by contacting the MD ARLN Regional Laboratory at mdphl.arln@maryland.gov. See the attached illustrated directions on page 3 for an example case for completing Form No. 4676. A blank Infectious Agents Culture Detection form No. 4676 is available on page 4. The form must be completed when submitting pre-approved specimens for all AMR reference test requests to the Maryland ARLN Laboratory. Specimens submitted without this form will NOT be accepted for testing. Please ensure that all required core demographic, provider, and patient contact information is completed.

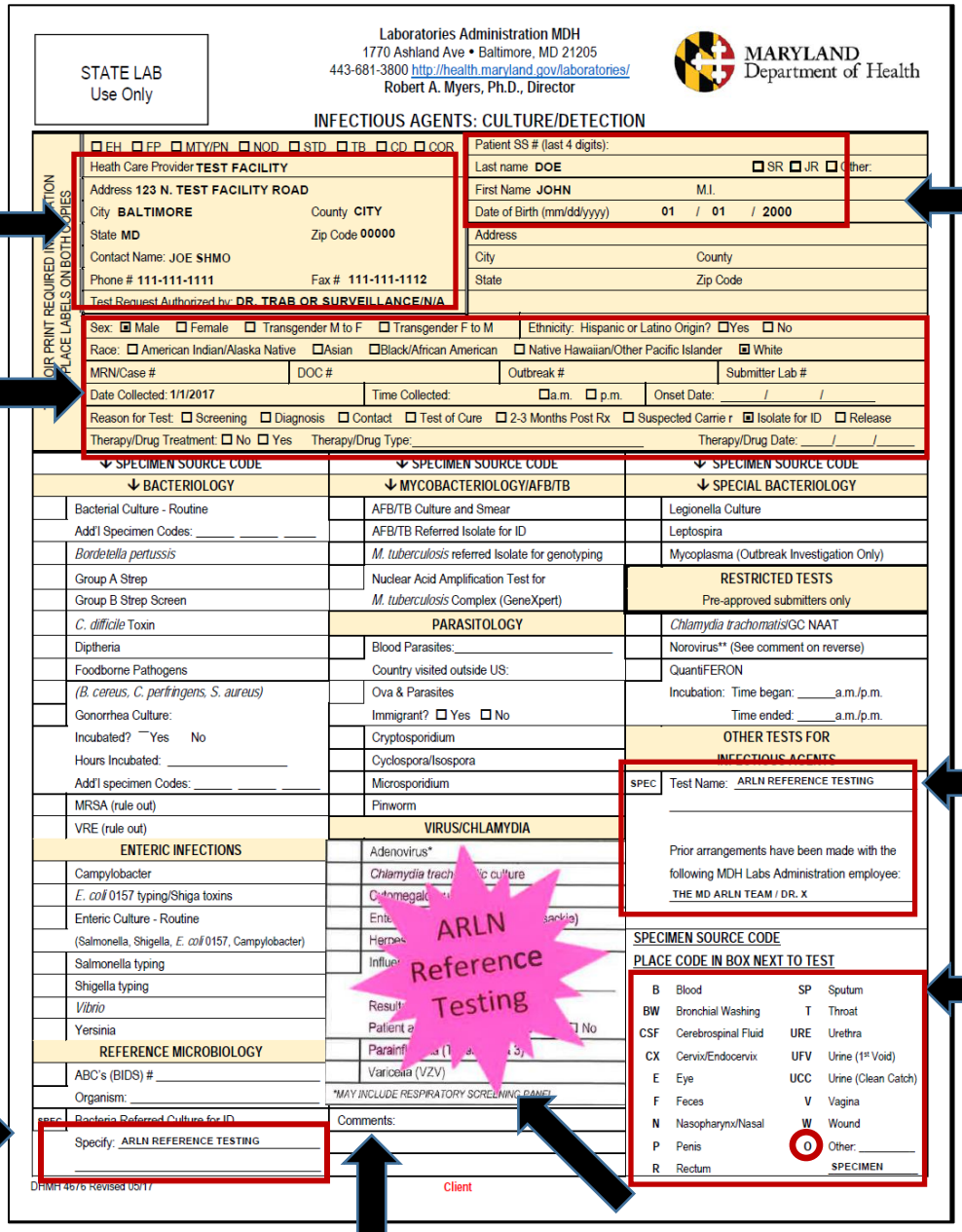
3. Enclose a completed test request form with each specimen/isolate that is submitted for reference testing.

4. Isolates can be transferred within the U.S. as Category B Biological Substances in accordance with Department of Transportation (DoT) Hazardous Materials Regulations (49 CRF Part 171-180). Guidance for packaging samples in accordance with Category B Biological substance requirements can be found in the CDC/NIH Publication Biosafety in Microbiological and BioMedical Laboratories, 5th edition. Additional information about the DoT Hazardous Materials Transport Regulations can be found at https://www.transportation.gov/pipelines-hazmat. A supply of pre-printed shipping labels have been provided for your convenience. Appropriately packaged specimens can be shipped directly using the ARLN FEDEX account to the following address:
   Maryland Department of Health Laboratories Administration
   Attn: ARLN Regional Laboratory
   1770 Ashland Ave
   Baltimore, Maryland 21205
   Email the MD ARLN laboratory at mdphl.arln@maryland.gov about the shipment & the expected receipt date with the FedEx tracking.

Must complete the submitting entity information **(This is where reports will be sent)** & include name of practitioner requesting the test.

Complete the patient demographic information such as sex, MRN/Case#, Date collected, time collected, outbreak # and submitter Lab # if available

Check the box and indicate test name by writing CRE Testing or ARLN AMR on the line. Enter Species ID if available.



Patient's first & last names must be on the specimen container and exactly match the test request form

Write "ARLN AMR reference testing" to request testing and enter source code of the specimen/isolate

Using this specimen source code, enter the code in the box next to the test name.

If other, please identify the source

Include any comments here

Affix the color coded label

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

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

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 Carrie r ☐ Isolate for ID ☐ Release
Therapy/Drug Treatment: ☐ No ☐ Yes Therapy/Drug Type:_____ Therapy/Drug Date: ____/____/____

↓ SPECIMEN SOURCE CODE

↓ BACTERIOLOGY

- ☐ Bacterial Culture - Routine
  - Add'l Specimen Codes: _____ _____ _____
- ☐ *Bordetella pertussis*
- ☐ Group A Strep
- ☐ Group B Strep Screen
- ☐ *C. difficile* Toxin
- ☐ Diptheria
- ☐ 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* 0157 typing/Shiga toxins
- ☐ Enteric Culture - Routine
  - (Salmonella, Shigella, *E. coli* 0157, 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

- ☐ AFB/TB Culture and Smear
- ☐ AFB/TB Referred Isolate for ID
- ☐ *M. tuberculosis* referred Isolate for genotyping
- ☐ Nuclear Acid Amplification Test for *M. tuberculosis* Complex (GeneXpert)

PARASITOLOGY

- ☐ Blood Parasites:_____
- Country visited outside US:
- ☐ Ova & Parasites
  - Immigrant? ☐ Yes ☐ No
- ☐ Cryptosporidium
- ☐ Cyclospora/Isospora
- ☐ Microsporidium
- ☐ Pinworm

VIRUS/CHLAMYDIA

- ☐ Adenovirus*
- ☐ *Chlamydia trachomatic* culture
- ☐ Cytomegalovirus (CMV)
- ☐ Enterovirus (Includes Echo & Coxsackie)
- ☐ Herpes Simplex Virus (Types 1 & 2)
- ☐ Influenza (Types A & B)* Rapid Flu Test:
  - Type:_____
  - Result: ☐ Negative ☐ Positive
  - Patient admitted to hospital? ☐ Yes ☐ No
- ☐ Parainfluenza (Types 1, 2 & 3)*
- ☐ Varicella (VZV)

*MAY INCLUDE RESPIRATORY SCREENING PANEL

Comments:

↓ SPECIMEN SOURCE CODE

↓ SPECIAL BACTERIOLOGY

- ☐ Legionella Culture
- ☐ Leptospira
- ☐ 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

- ☐ Test Name: _____

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

SPECIMEN SOURCE CODE
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		

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