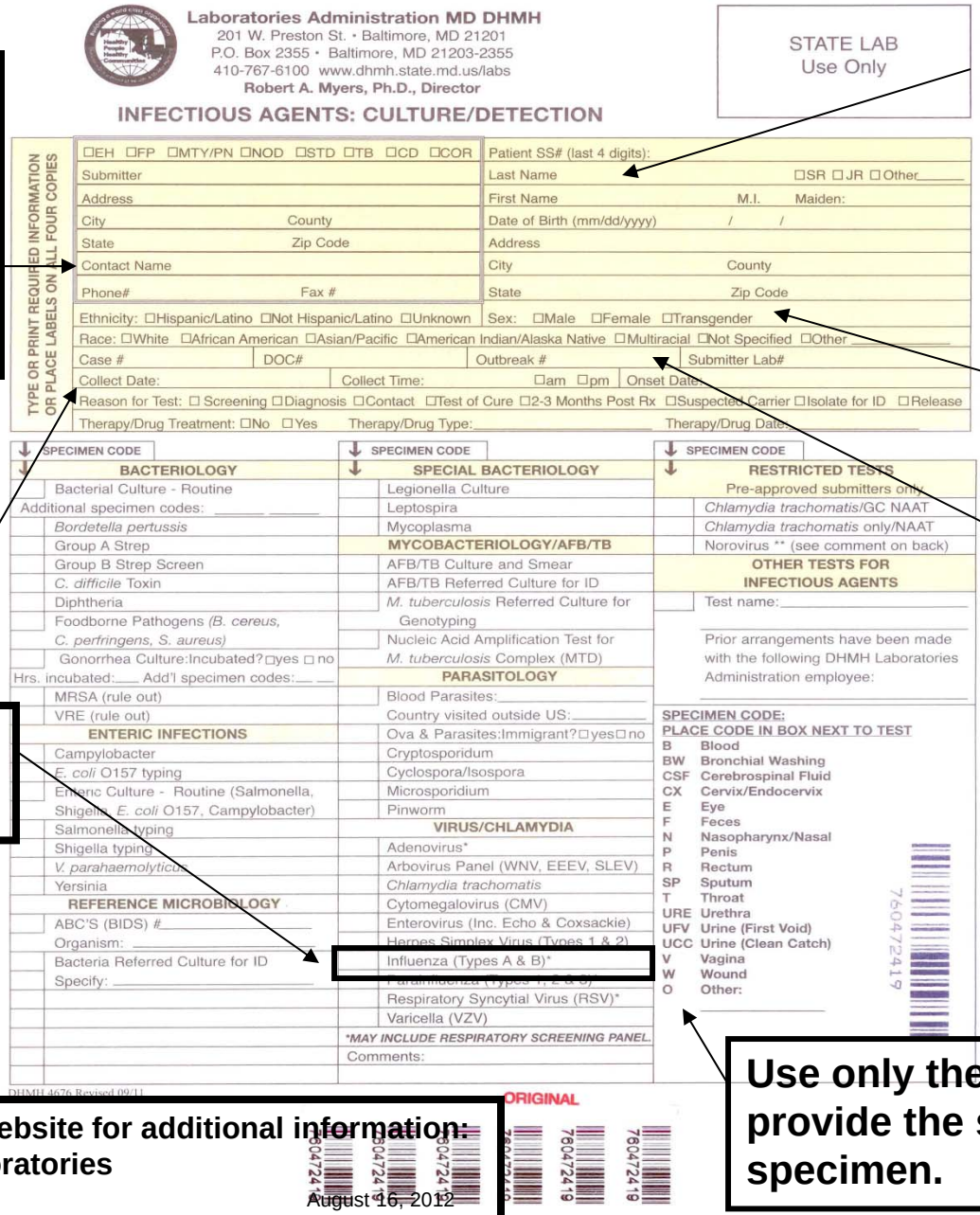
Influenza (Types A & B) Test Request Sample Form



Laboratories Administration MD DHMH
201 W. Preston St. • Baltimore, MD 21201
P.O. Box 2355 • Baltimore, MD 21203-2355
410-767-6100 www.dhmh.state.md.us/labs
Robert A. Myers, Ph.D., Director

INFECTIOUS AGENTS: CULTURE/DETECTION

STATE LAB Use Only

TYPE OR PRINT REQUIRED INFORMATION OR PLACE LABELS ON ALL FOUR COPIES

☐EH ☐FP ☐MTY/PN ☐NOD ☐STD ☐TB ☐CD ☐COR
Submitter
Address
City County
State Zip Code
Contact Name
Phone# Fax #

Patient SS# (last 4 digits):
Last Name ☐SR ☐JR ☐Other
First Name M.I. Maiden:
Date of Birth (mm/dd/yyyy) / /
Address
City County
State Zip Code

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
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)*
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) #_____
Organism: _____
Bacteria Referred Culture for ID
Specify: _____

SPECIMEN CODE

SPECIAL BACTERIOLOGY
Legionella Culture
Leptospira
Mycoplasma

MYCOBACTERIOLOGY/AFB/TB
AFB/TB Culture and Smear
AFB/TB Referred Culture for ID
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
Cryptosporidum
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)
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:_____

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
UFV	Urine (First Void)
UCC	Urine (Clean Catch)
V	Vagina
W	Wound
O	Other:

7604724 19

DHMH 4676 Revised 09/11

ORIGINAL

7604724 19 7604724 19 7604724 19 7604724 19 7604724 19

Must complete submitter information and include the name of the <u>authorized person requesting</u> the test.

Fill in the date specimen was collected.

Indicate the specimen source next to **the <u>Influenza (Types A &B) Test</u>** requested.

Go to the DHMH Laboratory website for additional information: www.dhmh.maryland.gov/laboratories

Patient's first and last names must be on the specimen container and match exactly to the lab slip.

Indicate patient's race, ethnicity and sex.

If applicable, complete the outbreak number field.

Use only these codes to provide the source of the specimen.