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 Onset Date Field.

SPECIMEN SOURCE CODE	SPECIMEN SOURCE CODE	SPECIMEN SOURCE CODE
	MYCOBACTERIOLOGY/AFB/TB	SPECIAL BACTERIOLOGY
	AFB/TB Culture and Smear	L
	AFB/TB Referred Isolate for ID	L
	M. tuberculosis referred Isolate for genotyping	Mycoplasma (Outbreak Investigation Only)
Group A Strep	Nuclear Acid Amplification Test for	RESTRICTED TESTS
Group B Strep Screen	*M. tuberculosis* Complex (GeneXpert)	Pre-approved submitters only
C. difficile Toxin	PARASITOLOGY	*Chlamydia trachomatis*/GC NAAT
Diphtheria	Blood Parasites:_____	**Norovirus (See comment on reverse)
Foodborne Pathogens	Country visited outside US:	QuantiFERON
(B. cereus, C. perfringens, S. aureus)	Ova & Parasites	Incubation: Time began: _____a.m./p.m.
Gonorrhea Culture:		Time ended: _____a.m./p.m.
Incubated? ☐Yes ☐ No		OTHER TESTS FOR
Hours Incubated: _____		INFECTIOUS AGENTS
Add'l specimen Codes: _____ _____ _____	Microsporidium	Test Name:
MRSA (rule out)	Pinworm	
VRE (rule out)	VIRUS/CHLAMYDIA	
ENTERIC INFECTIONS	Adenovirus*	Prior arrangements have been made with the following MDH Labs Administration employee:
Campylobacter	*Chlamydia trachomatis* culture	Note Name of Lab Personnel or Epidemiologist Here
(Salmonella, Shigella, *E. coli* O157, Campylobacter)	Cytomegalovirus (CMV)	
Salmonella typing	Enterovirus (Includes Echo & Coxsackie)	
Shigella typing	Herpes Simplex Virus (Types 1 & 2)	
Vibrio	Influenza (Types A & B)* Rapid Flu Test:	
Yersinia	Type:_____	
REFERENCE MICROBIOLOGY	Result: ☐ Negative ☐ Positive	
ABC's (BIDS) # _____	Patient admitted to hospital? ☐ Yes ☐ No	
Organism: _____	Parainfluenza (Types 1, 2 & 3)*	
Bacteria Referred Culture for ID	Respiratory Syncytial Virus (RSV)*	
Specify: _____	VARICELLA (VZV)	
_____	NG PANEL	

Mandatory: Make note "Avian Influenza PCR" in Other Tests box.

Avian Influenza PCR

Mandatory: Order Influenza Test Using Specimen Code

NP

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

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		