STATE LAB
Use Only

Laboratories Administration MDH
1770 Ashland Ave • Baltimore, MD 21205
443-681-3800 http://health.maryland.gov/laboratories/
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MARYLAND Department of Health

INFECTIOUS AGENTS: CULTURE/DETECTION

TYPE OIR PRINT REQUIRED INFORMATION OR PLACE LABELS ON BOTH COPIES

☐ EH ☐ FP ☐ MTY/PN ☐ NOD ☐ STD ☐ TB ☐ CD ☐ COR	Patient SS # (last 4 digits):
Health Care Provider	Last name ☐ SR ☐ JR ☐ Other:
Address	First Name M.I.
City County	Date of Birth (mm/dd/yyyy) / /
State Zip Code	Address
Contact Name:	City County
Phone # Fax #	State Zip Code
Test Request Authorized by:	

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: _____/_____/_____

↓ SPECIMEN SOURCE CODE	↓ SPECIMEN SOURCE CODE	↓ SPECIMEN SOURCE CODE
↓ BACTERIOLOGY	**↓ MYCOBACTERIOLOGY/AFB/TB**	**↓ SPECIAL BACTERIOLOGY**
☐ Bacterial Culture - Routine	☐ AFB/TB Culture and Smear	☐ Legionella Culture
Add'l Specimen Codes: ______ ______ _____	☐ AFB/TB Referred Isolate for ID	☐ Leptospira
☐ *Bordetella pertussis*	☐ *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
☐ Diptheria	☐ 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:	Immigrant? ☐ Yes ☐ No	Time ended: ______ ☐ a.m. ☐ p.m.
Incubated? ☐Yes ☐ No	☐ Cryptosporidium	**OTHER TESTS FOR**
Hours Incubated: _________________	☐ Cyclospora/Isospora	**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
☐ Campylobacter	☐ *Chlamydia trachomatic* culture	following MDH Labs Administration employee:
☐ *E. coli* 0157 typing/Shiga toxins	☐ Cytomegalovirus (CMV)	______________________________________
☐ Enteric Culture - Routine	☐ Enterovirus (Includes Echo & Coxsackie)	
(Salmonella, Shigella, *E. coli* 0157, Campylobacter)	☐ Herpes Simplex Virus (Types 1 & 2)	
☐ Salmonella typing	☐ Influenza (Types A & B)* Rapid Flu Test:	
☐ Shigella typing	Type:_____________________________	
☐ *Vibrio*	Result: ☐ Negative ☐ Positive	
☐ Yersinia	Patient admitted to hospital? ☐ Yes ☐ No	
REFERENCE MICROBIOLOGY	☐ Parainfluenza (Types 1, 2 & 3)*	
☐ ABC's (BIDS) # ____________________	☐ Varicella (VZV)	
Organism: ________________________	**MAY INCLUDE RESPIRATORY SCREENING PANEL*	
☐ Bacteria Referred Culture for ID	Comments:	
Specify: __________________________		
__________________________________		

SPECIMEN SOURCE CODE

PLACE CODE IN BOX NEXT TO TEST

Code	Source	Code	Source
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		_____________

CLINIC CODES

EH- Employee Health
FP-Family Planning
MTY/PN-Maternity/Prenatal
NOD-Nurse of Day
STD/STI-Sexually Transmitted Disease/Infections
CD-Communicable Disease
COR-Correctional Facility
Do not mark a box if clinic type does not apply

COMPLETING FORM

Type or print legibly
Printed labels are recommended
Place printed labels on all copies of form
Press **firmly** –two part form
Collection date is required by law
Write collection time when appropriate, test specific

WRITE SPECIMEN CODE in box next to test

Specimens/samples can not be processed without a requested test.

NOROVIRUS –Outbreak Number Required

Appropriate for outbreak and epidemiological investigations **only**

A MDH Outbreak Number is required.

Contact your local health department for a MDH Outbreak Number

Questions/comments on the use of the specimen bags/storage/shipping or completing the form contact:
Questions/comments on the use of the specimen bags/storage/shipping or completing the form contact:
Accessioning Unit 443-681-3842 or 443-681-3793

To order specimen collection supplies contact:
Outfits Unit: 443-681-3777 or443-681-3776

For Specific Test Requirements Refer to:
Guide to Public Health Laboratory Services
Available on line:
https://health.maryland.gov/laboratories/Pages/Home.aspx

LABELING SPECIMENS/SAMPLES

Printed labels with all required patient information are recommended

Print patient name, date of birth
Print date and time the specimen was collected
DO NOT cover expiration date of collection container

Write specimen source on collection containers when collecting specimens from multiple sites/sources

PACKAGING SPECIMENS FOR TRANSPORT

Never place specimens with different temperature requirements in the same biobag

Use one (1) biobag per temperature requirement

Review test request form to ensure all test(s) have been marked

Verify all specimens have been labeled

Place folded request form(s) in outer pouch of biobag

Multiple specimens from the same patient with the same temperature requirements must be packaged together in one (1) biobag

URINE SPECIMENS – Refrigerate PACKAGING AND SHIPPING

Double bag all urine specimens

Urine specimens require absorbent towel in biobag with specimen (express excess air before sealing)

Place bagged urine specimen in second biobag with all refrigerated specimens from the same patient

Place folded test request form(s) in outer pouch of second bag

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