

Mandatory: Complete Health Care Provider Section

Mandatory: Fill in TRAB box.

Mandatory: Complete Patient Information 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

INFECTIOUS AGENTS: CULTURE/DETECTION

TYPE OR PRINT REQUIRED INFORMATION OR PLACE LABELS ON BOTH COPIES

EH FP MT/YPN NOD STD TB CD COR

Health 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: _____ / _____ / _____

↓ SPECIMEN SOURCE CODE

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

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) _____

Mandatory: Complete specimen collection time field.

↓ MYCOBACTERIOLOGY/AFB/TB

Legionella _____

Leptospira _____

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 _____

Mandatory: Complete Onset Date Field.

↓ SPECIMEN SOURCE CODE

Chlamydia trachomatis/GC NAAT _____

Norovirus** (See comment on reverse) _____

QuantIFERON _____

Incubation: Time began: _____ a.m. p.m.

Time ended: _____ a.m. p.m.

ENTERIC INFECTIONS

Campylobacter _____

E. coli O157 typing/Shiga toxins _____

Enteric Culture - Routine (Salmonella, Shigella, E. coli O157, Campylobacter) _____

Salmonella typing _____

Shigella typing _____

Vibrio _____

Yersinia _____

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: _____

Result: Negative Positive

RESTRICTED TESTS

Pre-approved submitters only

OTHER TESTS FOR INFECTIOUS AGENTS

Mandatory: Order Test Using Specimen Code and Indicate MERS-CoV (Biofire Respiratory Panel)

Test Name: _____

MERS-CoV (Biofire Respiratory Panel)

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

Note Name of Lab Personnel or Epidemiologist Here

REFERENCE MICROBIOLOGY

ABC's (BIDS) # _____

Organism: _____

Bacteria Referred Culture for ID

Specify: _____

Comments: _____

*MAY INCLUDE RESPIRATORY SCREENING PANEL

TEST NAME

MERS-CoV (Biofire Respiratory Panel)

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

Note Name of Lab Personnel or Epidemiologist Here

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 (1 st Void)
E	Eye	UCC	Urine (Clean Catch)
F	Feces	V	Vagina
N	Nasopharynx/Nasal	W	Wound
P	Penis	O	Other: _____
R	Rectum		

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

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
Please place labels on all copies of the form
Write the person's name that is Authorized to order test(s) in the box provided (this may be added to the pre-printed label).
Press firmly –two part form
Collection date and time are required by Law.
WRITE SPECIMEN CODE in box next to test

***Specimen/samples cannot 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:
Accessioning Unit 443-681-3842 or 443-681-3793

To order collection kits and/or specimen collection supplies, contact:
Outfit Unit 443-681-3777 or Fax 443-681-3850

For Specific Test Requirements Refer to:
"Guide to Public Health Laboratory Services"
Available online: mdh.maryland.gov/laboratories

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 the collection container(s).

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.