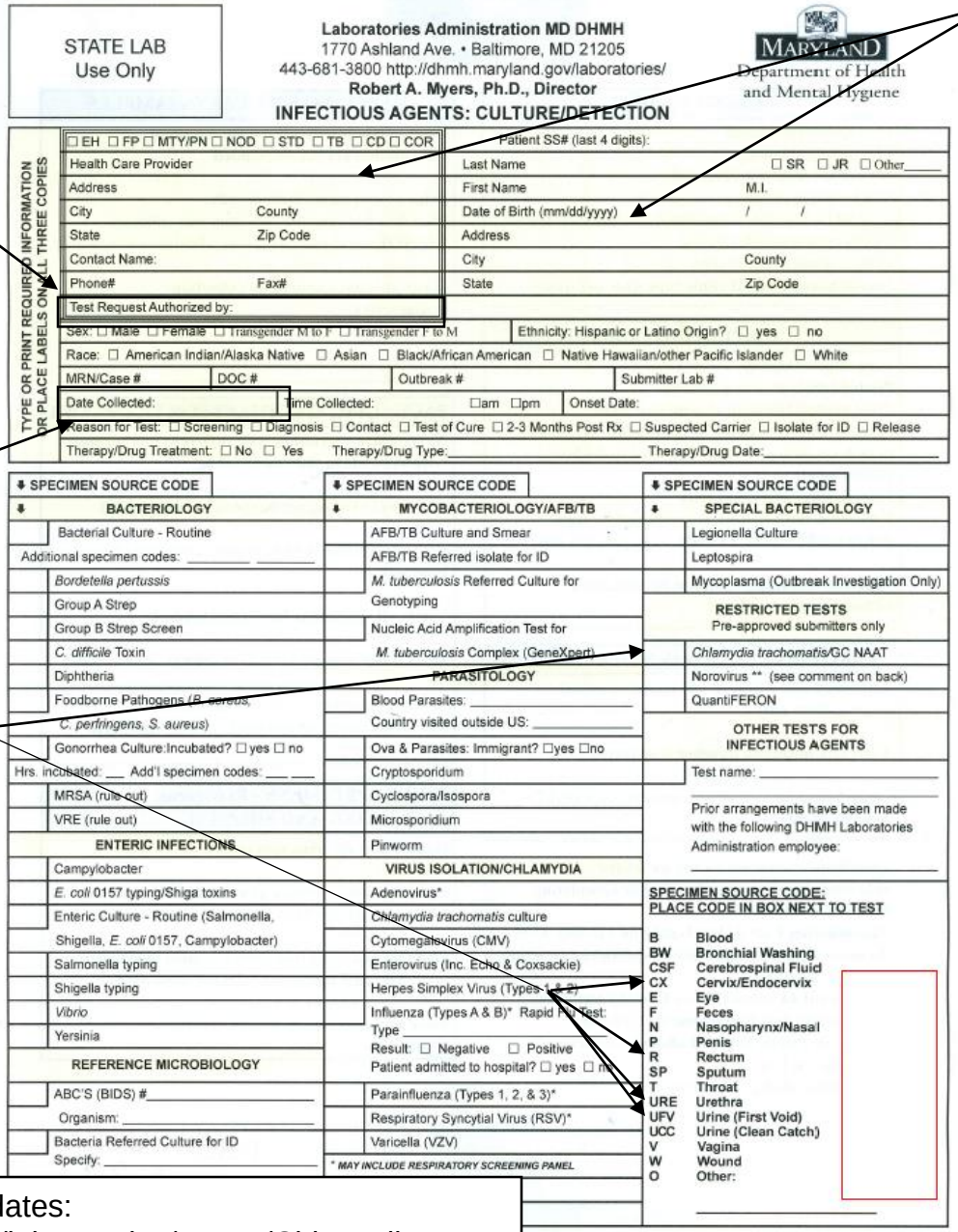
One lab slip MUST be completed for each sample submitted.

Fill in TRAB box or include TRAB name on your label or stamp.

Collect date must be completed

Use only these codes for specimen source. Write specimen source code next to the test requested. (CX, R, URE, V, T, or UFV)

Complete submitter and patient information sections including sex, ethnicity and race.



STATE LAB Use Only

Laboratories Administration MD DHMH
1770 Ashland Ave. • Baltimore, MD 21205
443-681-3800 http://dhmh.maryland.gov/laboratories/
Robert A. Myers, Ph.D., Director

MARYLAND Department of Health and Mental Hygiene

INFECTIOUS AGENTS: CULTURE/DETECTION

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

☐ EH ☐ FP ☐ MTY/PN ☐ 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

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: ☐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 SOURCE 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* 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 Culture for Genotyping
- Nucleic Acid Amplification Test for *M. tuberculosis* Complex (GeneXpert)

PARASITOLOGY
- Blood Parasites: _____
- Country visited outside US: _____
- Ova & Parasites: Immigrant? ☐yes ☐no
- Cryptosporidum
- Cyclospora/Isospora
- Microsporidium
- Pinworm

VIRUS ISOLATION/CHLAMYDIA
- Adenovirus*
- *Chlamydia trachomatis* culture
- Cytomegalovirus (CMV)
- Enterovirus (Inc. 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)*
- Respiratory Syncytial Virus (RSV)*
- Varicella (VZV)

* MAY INCLUDE RESPIRATORY SCREENING PANEL

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 back)
- QuantiFERON

OTHER TESTS FOR INFECTIOUS AGENTS
- Test name: _____

Prior arrangements have been made with the following DHMH Laboratories Administration employee: _____

SPECIMEN SOURCE 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: _____

2019 Chlamydia/GC NAAT MOU and Non-Sticker Allocation

Visit the lab website for updates:
https://health.maryland.gov/laboratories/Pages/Chlamydia.aspx