Mandatory: Complete Health Care Provider Section
(The address provided is the location where test results will be sent.)
Include the facility name.

Laboratories Administration MDH
1770
3-681-3
R

Mandatory: Fill in TRAB box.
(Complete field with full name and credentials)

MARYLAND Department of Health

CTIOUS AGENTS: CULTURE/DETECTION

Mandatory: Complete Patient Information Section.

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 specimen collection time field.

Mandatory: Complete Onset Date Field.

SPECIMEN SOURCE CODE

Group A Strep

Group B Strep Screen

C. difficile

Diphtheria

Foodborne

(B. cereus, C. perfringens, S. aureus)

Gonorrhea Culture:

Incubated? ☐ Yes ☐ No

Hours Incubated: _____

Add'l Specimen Codes: _____ _____ _____

MR

VR

Car

E. c

Ent

(Sal

Sal

Shi

Vib

Yersinia

REFERENCE MICROBIOLOGY

ABC's (BIDS) # _____

Organism: _____

Bacteria Referred Culture for ID

Specify: _____

_____

SPECIMEN SOURCE CODE

MYCOBACTERIOLOGY/AFB/TB

M. tuberculosis referred isolate for genotyping

Nuclear Acid Amplification Test for *M. tuberculosis* Complex (GeneXpert)

Immigrant? ☐ Yes ☐ No

Cryptosporidium

Cyclospora/Isospora

Microsporidium

Patient admitted to hospital? ☐ Yes ☐ No

Parainfluenza (Types 1, 2 & 3)*

Respiratory Syncytial Virus (RSV)*

VARICELLA (VZV)

*MAY INCLUDE RESPIRATORY SCREENING PANEL

Comments:

SPECIMEN SOURCE CODE

SPECIAL BACTERIOLOGY

Mycoplasma (Outbreak Investigation Only)

RESTRICTED TESTS

Pre-approved submitters only

Chlamydia trachomatis/GC NAAT

**Norovirus (See comment on reverse)

QuantiFERON

Incubation: Time began: _____a.m./p.m.

Time ended: _____a.m./p.m.

OTHER TESTS FOR INFECTIOUS AGENTS

N Test Name: _____

Mandatory: Write the Specimen Source Code in this box next to the test name. To obtain the Specimen Source Code refer to the list located at the bottom right side of the form. (e.g. "T" for Throat and "N" for Nasopharynx/Nasal).

COVID-19 Priority I Symptomatic

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

Note Name of Lab Personnel or Epidemiologist Here

Mandatory: Indicate COVID-19 Testing Priority Level (see below)
Priority I: Any Symptomatic Individual
Priority II: Asymptomatic Individual where COVID-19 exposure may be possible
Priority III: Healthcare Workers and First Responders
Priority IV: High-Risk Unstable Patient (care would be altered by diagnosis of COVID-19)
Priority V: Individuals Employed in Close Contact Settings
Priority VI: Individuals Previously In a Large Gathering

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		