Laboratories Administration MDH
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443-681-3800 http://health.maryland.gov/laboratories/
Robert A. Myers, Ph.D., Director

MARYLAND Department of Health

Mandatory: Complete Health Care Provider Section

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	Patient SS # (last 4 digits):
Address	Last Name ☐ SR ☐ JR ☐ Other:
City County	First Name M.I.
State Zip Code	Date of Birth (mm/dd/yyyy) / /
Contact Name:	Address
Phone # Fax #	City County
Test Request Authorized by:	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* Toxin
- ☐ Diphtheria
- ☐ Foodborne Pathogens
- ☐ (*B. cereus, C.*
- ☐ Gonorrhea Cu
- Incubated? ☐
- Hours Incubat
- Add'l specime
- ☐ MRSA (rule ou
- ☐ VRE (rule out)

ENTI

- ☐ Campylobacter
- ☐ *E. coli* O157 typing/Shiga toxins
- ☐ Enteric Culture - Routine
  (Salmonella, Shigella, *E. coli* O157, 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 S
- ☐ *M. tuberculosis* referred isolate for genotyping
- ☐ Nuclear Acid Amplification Test for *M. tuberculosis* Complex (GeneXpert)

PARASITOLOGY

- ☐ Blood Parasites:_____
- Country visited outside US:

Mandatory: Order Test Using Specimen Code and COVID-19. Indicate COVID-19 Testing Priority Level (see below):
Level A: Hospitalized Patient,
Level B: Symptomatic Front Line Responder
Level C: Symptomatic Patient in Nursing Home/Long-Term Care Facility
Level D: Symptomatic High-Risk Unstable Patient

- ☐ *Chlamydia trachomatis* culture
- ☐ Cytomegalovirus (CMV)
- ☐ Enterovirus (Includes Echo & Coxsackie)
- ☐ Herpes Simplex Virus (Types 1 & 2)
- ☐ Influenza (Types A & B)* Rapid Flu Test:
  Type:_____
- ☐ Respiratory Syncytial Virus (RSV)*
- ☐ VARICELLA (VZV)

*MAY INCLUDE RESPIRATORY SCREENING PANEL

Comments:

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

SPECIMEN SOURCE CODE

SPECIAL BACTERIOLOGY

- ☐ L
- ☐ L
- ☐ 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 _____ COVID-19 Priority A Hospitalized

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

Note Name of Lab Personnel or Epidemiologist Here

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		