Virus Isolation Test Requisition

Must complete submitter information and include the name of the authorized person requesting the test.

Fill in the date specimen was collected.

Indicate the specimen source next to **each** virus requested.

Go to the DHMH Laboratory website for further information: www.dhmh.maryland.gov/laboratories

Patient's first and last names must be on the specimen container and match exactly to the lab slip.

Indicate patient's race, ethnicity and sex.

If applicable, complete the outbreak number field.

Use only these codes to provide the source of the specimen.

2-106753

Laboratories Administration MD DHMH
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410-767-6100 www.dhmh.state.md.us/labs
Robert A. Myers, Ph.D., Director

STATE LAB Use Only

INFECTIOUS AGENTS: CULTURE/DETECTION

TYPE OR PRINT REQUIRED INFORMATION OR PLACE LABELS ON ALL FOUR 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. Maiden:
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
Case # DOC# Outbreak # Submitter Lab#
Collect Date: Collect Time: ☐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 CODE	BACTERIOLOGY	SPECIMEN CODE	SPECIAL BACTERIOLOGY	SPECIMEN CODE	RESTRICTED TESTS
	Bacterial Culture - Routine		Legionella Culture		Pre-approved submitters only
	Additional specimen codes:		Leptospira		*Chlamydia trachomatis*/GC NAAT
	Bordetella pertussis		Mycoplasma		*Chlamydia trachomatis* only/NAAT
	Group A Strep		**MYCOBACTERIOLOGY/AFB/TB**		Norovirus ** (see comment on back)
	Group B Strep Screen		AFB/TB Culture and Smear		**OTHER TESTS FOR INFECTIOUS AGENTS**
	C. difficile Toxin		AFB/TB Referred Culture for ID		Test name:
	Diphtheria		*M. tuberculosis* Referred Culture for Genotyping		
	Foodborne Pathogens (*B. cereus, C. perfringens, S. aureus*)		Nucleic Acid Amplification Test for *M. tuberculosis* Complex (MTD)		Prior arrangements have been made with the following DHMH Laboratories Administration employee:
	Gonorrhea Culture: Incubated? ☐yes ☐no Hrs. incubated: Add'l specimen codes:		**PARASITOLOGY**		
	MRSA (rule out)		Blood Parasites:		**SPECIMEN CODE: PLACE CODE IN BOX NEXT TO TEST**
	VRE (rule out)		Country visited outside US:		B Blood
	ENTERIC INFECTIONS		Ova & Parasites: Immigrant? ☐yes ☐no		BW Bronchial Washing
	Campylobacter		Cryptosporidium		CSF Cerebrospinal Fluid
	E. coli O157 typing		Cyclospora/Isospora		CX Cervix/Endocervix
	Enteric Culture - Routine (Salmonella, Shigella, *E. coli* O157, Campylobacter)		Microsporidium		E Eye
			Pinworm		F Feces
	Salmonella typing		**VIRUS ISOLATION/CHLAMYDIA**		N Nasopharynx/Nasal
	Shigella typing		Adenovirus*		P Penis
	V. parahaemolyticus		Arbovirus Panel (WNV, EEEV, SLEV)		R Rectum
	Yersinia		*Chlamydia trachomatis*		SP Sputum
	REFERENCE MICROBIOLOGY		Cytomegalovirus (CMV)		T Throat
	ABC'S (BIDS) #		Enterovirus (Inc. Echo & Coxsackie)		URE Urethra
	Organism:		Herpes Simplex Virus (Types 1 & 2)		UFV Urine (First Void)
	Bacteria Referred Culture for ID		Influenza (Types A & B)*		UCC Urine (Clean Catch)
	Specify:		Parainfluenza (Types 1, 2 & 3)*		V Vagina
			Respiratory Syncytial Virus (RSV)*		W Wound
			Varicella (VZV)		O Other:
			*MAY INCLUDE RESPIRATORY SCREENING PANEL		
			Comments:		

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ORIGINAL