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 ☐MTY/PN ☐NOD ☐STD/STI ☐ TB ☐ CD ☐ COR

| | |
|---|---|
| Heath Care Provider/ Facility | 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 |

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 # | Dept. of Corrections # | 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 — BACTERIOLOGY

- ☐ Bacterial Culture - Routine
- ☐ *Bordetella pertussis*
- ☐ Group A Strep-Clinical
- ☐ Group B Strep Screen-Clinical
- ☐ *C. difficile* Toxin
- ☐ Diphtheria
- ☐ Foodborne Pathogens *(B. cereus, C. perfringens, S. aureus)*
- ☐ Gonorrhea Culture: Incubated? ☐Yes ☐ No Hours Incubated: ____
- ☐ MRSA (rule out)
- ☐ VRE (rule out)

### ENTERIC INFECTIONS

- ☐ Campylobacter
- ☐ *E. coli* O 157 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: _____

### MYCOBACTERIOLOGY/AFB/TB

- ☐ AFB/TB Culture and Smear
- ☐ AFB/TB Referred Isolate for ID
- ☐ *M. tuberculosis* referred Isolate for genotyping
- ☐ NUCLEIC Acid Amplification Test for *M. tuberculosis* Complex (GeneXpert)

## SPECIMEN SOURCE CODE — PARASITOLOGY

- ☐ Blood Parasites _____ Country visited outside US: _____
- ☐ Ova & Parasites Immigrant? ☐ Yes ☐ No
- ☐ Cryptosporidium
- ☐ Cyclospora/Isospora
- ☐ Microsporidium
- ☐ Pinworm

### VIROLOGY

- ☐ *Chlamydia trachomatis* Culture
- ☐ Cytomegalovirus (CMV)
- ☐ Herpes Simplex Virus (Types 1 & 2)
- ☐ Varicella (VZV)
- ☐ Enterovirus*
- ☐ COVID-19 (SARS-CoV-2)*
- ☐ Influenza (Types A & B)*
  POC Testing Method: _____
  Result: ☐ Negative ☐ Positive infA ☐ Positive infB
  Patient admitted to hospital? ☐ No ☐ Yes
  Subtype (If applicable): _____
- ☐ NIRV (Non-Influenza Respiratory Viruses)* (Might include: Adenovirus, Human Metapneumovirus (hMPV), Respiratory Syncytial Virus (RSV), and Parainfluenza viruses 1 - 3)

*MIGHT INCLUDE RESPIRATORY SCREENING PANEL

Comments: _____

☐ **MUST ALSO MARK A TEST Submitted For Surveillance and/ or Regulatory Compliance**
**(Test Result(s) Not Issued)**
**Surveillance Program (If Applicable):** _____

## SPECIMEN SOURCE CODE — SPECIAL BACTERIOLOGY

- ☐ Legionella Culture
- ☐ Leptospira
- ☐ Mycoplasma (Outbreak Investigation Only)

### RESTRICTED TESTS Pre-approved submitters only

- ☐ *Chlamydia trachomatis*/GC NAAT
- ☐ **Norovirus-Outbreak Number Required
- ☐ QuantiFERON Incubation: Time Began: ____ ☐a.m. ☐p.m. Time ended: ____ ☐a.m. ☐p.m.

### Antibiotic Resistance Lab Network- ARLN

- ☐ Carbapenem Resistance Reference
- ☐ Yeast Culture Reference
- ☐ Aspergilus fumigatus Azole Testing

### OTHER TESTS FOR INFECTIOUS AGENTS

- ☐ Test Name: _____

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

**Specimen Receipt Temperature (For MDH Lab Use ONLY):**

_____ °C

**SPECIMEN SOURCE CODES PLACE CODE IN BOX NEXT TO TEST**

| | | | |
|---|---|---|---|
| B | Blood Specimen | SP | Sputum Specimen |
| BAL | Bronchoalveolar lavage fluid sample | T | Throat Swab |
| BW | Bronchial Washings | URE | Urethral Swab |
| CSF | Cerebrospinal Fluid Sample | UFV | Urine (1st Void) |
| CX | Cervical Swab | UCC | Urine (Clean Catch) |
| N | Nasal Swab | V | Vaginal Swab |
| NP | Nasopharyngeal Swab | W | Wound Swab |
| P | Penis Swab | O | Other: _____ |
| R | Rectum Swab | | |
| S | Stool Specimen | | |



Client

## CLINIC CODES

EH – Employee Health
FP – Family Planning
MTY/PN – Maternity/Prenatal
NOD – Nurse of Day
STD/STI – Sexually Transmitted Disease/Infections
TB- Tuberculosis
CD- Communicable Disease
COR – Correctional Facility

**Do not mark a box if clinic type does not apply**

## COMPLETING FORM

Press firmly – two part form

Type or print legibly

Printed labels are recommended

Please place labels on all copies of the form

Print or type the name of the person authorized to order test(s)
**(This may be added to the pre-printed label.)**

**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 Information:**

**Outfit Unit 443-681-3777 or Fax 443-681-3850**

**E-mail mdhlabs.outfits@maryland.gov**

**For specific test requirements refer to:**

**"Guide to Public Health Laboratory Services"**

**Available Online:**

**health.maryland.gov/laboratories/Pages/home.aspx**

## 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 bio-bag.**

Review the Test Request Form to verify completeness including that the desired test(s) has/have been marked.

Use a separate bio-bag for each form and each temperature requirement. Place the specimen container in the zip lock portion of the bio-bag and seal it closed. Place the folded Test Request Form in the outside pocket of the bio-bag.

If multiple specimen containers are required for various tests marked on 1 form, place each container in a separate bio-bag to protect it from leakage/breakage of the other containers. Then place them all into an outer bio-bag with the Test Request Form in the pocket.

**Verify that all specimen containers have been labeled as described above.**

## URINE SPECIMENS – Refrigerate PACKAGING AND SHIPPING

**Double bag urine containers.** Include absorbent material in the inner bio-bag and express air before sealing. Place this in a second bio-bag with the folded Test Request Form in the pocket of the outer bio-bag. Transport at refrigerated temperature.