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 RESPIRTORY SCREENING PANEL

Comments: _____

☐ **Submitted For Regulatory Compliance and/or Surveillance* ***
(Test Result(s) Not Issued)
SurveillanceProgram (If Applicable):
_____
**Must also mark a test condition

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	Nasopharyngeal Swab	V	Vaginal Swab
P	Penis Swab	W	Wound Swab
R	Rectum Swab	O	Other: _____
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.