STATE LAB Use Only

Laboratories Administration MDH

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INFECTIOUS AGENTS: CULTURE/DETECTION

	□EH □FP □MTY/PN □NOD □STD □TB □CD □COR		Patient SS # (last 4 digits):					
TYPE OIR PRINT REQUIRED INFORMATION OR PLACE LABELS ON BOTH COPIES	Health Care Provider	Last name ☐ SR ☐ JR ☐ Other:						
	Address		First Name M.I.					
	City County		Date of Birth (mm/dd/yyyy) / /					
	State Zip Code		Address					
D IN	Contact Name:		City County					
JIRE ON E	Phone # Fax #		State Zip Code					
EOL	Test Request Authorized by:		·					
NT R LABI	Sex: □ Male □ Female □ Transgender M to F □ Transgender F to M Ethnicity: Hispanic or Latino Origin? □ Yes □ No							
PRI ACE	Race: ☐ American Indian/Alaska Native ☐ A	nerican Native Hawaiian/Other Pacific Islander White						
S OF	MRN/Case # DOC #	Outbreak # Submitter Lab #						
YPE	Date 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						□ Release	
	Therapy/Drug Treatment: No Yes Therapy/Drug Type: Therapy/Drug Date:/							
↓ SPE	ECIMEN SOURCE CODE	◆ SPECIMEN SOURCE CODE		◆ SPECIMEN SOURCE CODE				
	◆ BACTERIOLOGY		ERIOLOGY/AFB/TB		↓ SPECI	AL BACTERI	OLOGY	
Bacterial Culture - Routine		AFB/TB Culture and Smear		Legionella Culture				
Add'l Specimen Codes:		AFB/TB Referred Isolate for ID			Leptospira			
E	Bordetella pertussis	M. tuberculosis referred Isolate for genotyping		Mycoplasma (Outbreak Investigation Only)				
(Group A Strep	lification Test for	on Test for RESTRICTED TESTS					
(Group B Strep Screen	B Strep Screen M. tuberculosis Co			Pre-approved submitters only			
(C. difficile Toxin	PARASITOLOGY		Chlamydia trachomatis/GC NAAT				
[otheria Blood Parasites:_				Norovirus** (Se	s** (See comment on reverse)		
F	Foodborne Pathogens	Country visited outside US:		QuantiFERON				
(B. cereus, C. perfringens, S. aureus)	Ova & Parasites		Incubation: Time began: a.m. p.m.				
(Gonorrhea Culture:	 Immigrant? □ Ye	s □ No	Time ended: a.m. □ p.m.				
	ncubated? □Yes □ No	Cryptosporidium		OTHER TESTS FOR				
F	Hours Incubated:	Cyclospora/Isospora		INFECTIOUS AGENTS				
P	Add'l specimen Codes:	Microsporidium			Test Name:			
Λ	/IRSA (rule out)	Pinworm						
١	/RE (rule out)	VIRUS/	CHLAMYDIA					
·	ENTERIC INFECTIONS	Adenovirus*		Prior arrangements have been made with the				
(mpylobacter Chlamydia traci		<i>matic</i> culture		following MDH Labs Administration employee:			
E	E. coli 0157 typing/Shiga toxins	Cytomegalovirus (CMV)					
E	Enteric Culture - Routine	Enterovirus (Includ	les Echo & Coxsackie)					
(Salmonella, Shigella, E. coli 0157, Campylobacter)		Herpes Simplex Virus (Types 1 & 2)		SPECIMEN SOURCE CODE				
5	Salmonella typing	Influenza (Types A	A & B)* Rapid Flu Test:	PLAC	CE CODE IN BOX	(NEXT TO T	<u>EST</u>	
5	Shigella typing	Type:		В	Blood	SP	Sputum	
l	/ibrio	Result: Negativ	ve □ Positive	BW	Bronchial Wash	ing T	Throat	
Υ	'ersinia	Patient admitted to	hospital?	CSF	Cerebrospinal F	luid URE	Urethra	
	REFERENCE MICROBIOLOGY	Parainfluenza (Typ	pes 1, 2 & 3)*	СХ	Cervix/Endocerv	vix UFV	Urine (1st Void)	
	ABC's (BIDS) #	Varicella (VZV)		E	Eye	UCC	Urine (Clean Catch)	
Organism:		*MAY INCLUDE RESPIRATORY SCREENING PANEL		F	Feces	V	Vagina	
E	Bacteria Referred Culture for ID	Comments:		N	Nasopharynx/Na	asal W	Wound	
5	Specify:			Р	Penis	0	Other:	

CLINIC CODES

EH - Employee Health

FP - Family Planning

MTY/PN - Maternity/Prenatal

NOD - Nurse of Day

STD/STI - Sexually Transmitted Disease/Infections

CD- Communicable Disease

COR - Correctional Facility

Do not mark a box if clinic type does not apply

COMPLETING FORM

Type or print legibly

Print labels are recommended

Please print labels on all copies of form

Print of type the name of the person Authorized to order test(s) (this may be added to the preprinted label).

Press firmly – two part form

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:

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

For Specific Test Requirements Refer to:
"Guide to Public Health Laboratory Services"
Available online: mdh.maryland.gov/laboratories

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 biobag.

Use one (1) biobag per temperature requirement.

Review test request form to ensure all test(s) have been marked.

Verify all specimens have been labeled.

Place folded request form(s) in outer pouch of biobag.

Multiple specimens from the same patient with the same temperature requirements must be packaged together in one (1) biobag.

URINE SPECIMENS – Refrigerate PACKAGING AND SHIPPING

Double bag all urine specimens.

Urine specimens require absorbent towel in biobag with specimen (express excess air before sealing).

Place bagged urine specimen in second biobag with all refrigerated specimens from the same patient.

Place folded test request form(s) in outer pouch of second bag.