STATE LAB

Example: Influenza Diagnostic

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
Address
City | County
State | Zip Code
Contact
Phone # | Fax #
Test Request Authorized by

1) Health Care Provider - Facility location (REQUIRED)
2) Test Request Authorized By (TRAB) – Name and credentials of ordering clinician/provider (REQUIRED)

Patient SS # (last 4 digits)
Last Name ☐ SR ☐ JR ☐ Other
First Name M.I.
Date of Birth (mm/dd/yyyy)
Address
City | County
State | Zip Code

3) Patient's First and Last Name (REQUIRED)
4) Date of Birth (REQUIRED)
5) Patient Address

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

6) Patient Demographics

MRN/Case # | Dept. of Corrections # | Outbreak # | Submitter Lab #

Date Collected: **7) Date Collected (REQUIRED)** | Time Collected: **8) Time (REQUIRED)** ☐ p.m. | Onset Date: **9) Onset Symptoms (REQUIRED)**

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

Code	Test
	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

Code	Test
	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

Code	Test
	ABC's (BIDS) # ____ Organism:
	Bacteria Referred Culture for ID Specify:

MYCOBACTERIOLOGY/AFB/TB

Code	Test
	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

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

VIROLOGY

Code	Test
	Chlamydia trachomatis Culture
	Cytomegalovirus (CMV)
	Herpes Simplex Virus (Types 1 & 2)
	Varicella (VZV)
	Enterovirus*
	COVID-19 (SARS-CoV-2)*
NP	Influenza (Types A & B)* POC Testing Method: N/A 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)

10) REQUIRED

*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

Code	Test
	Legionella Culture
	Leptospira
	Mycoplasma (Outbreak Investigation Only)

RESTRICTED TESTS Pre-approved submitters only

Code	Test
	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

Code	Test
	Carbapenem Resistance Reference
	Yeast Culture Reference
	Aspergilus fumigatus Azole Testing

OTHER TESTS FOR INFECTIOUS AGENTS

Code	Test
	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

Code	Source	Code	Source
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		Wound Swab
R	Rectum Swab	O	Other: ____
S	Stool Specimen		

11) REQUIRED

***** Test results will only be returned to the Authorized Health Care Provider *****

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.