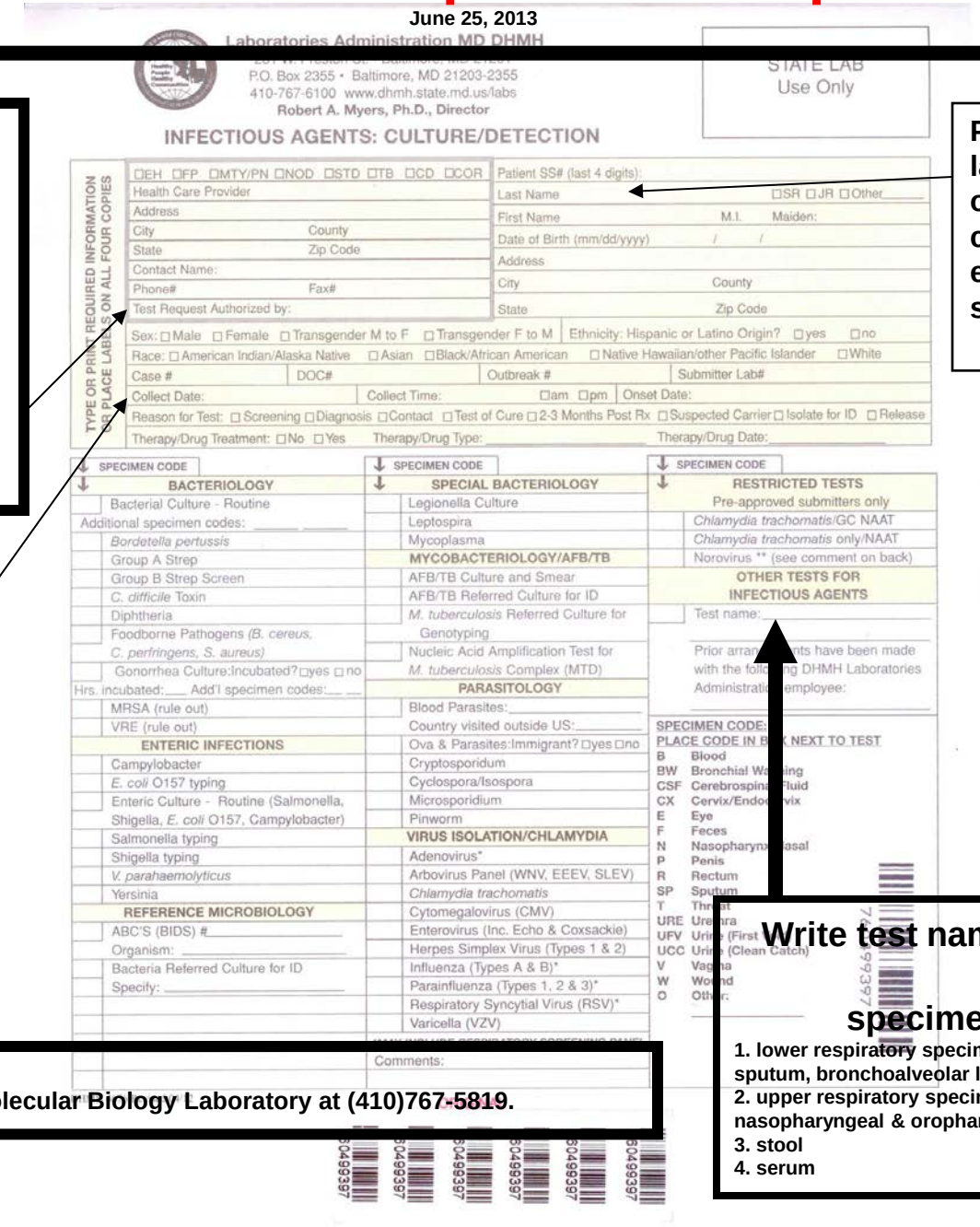
# MERS-CoV Test Requisition Sample Form



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Laboratories Administration MD DHMH
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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 |
|---|---|
| | Bacterial Culture - Routine |
| | Additional specimen codes: |
| | *Bordetella pertussis* |
| | Group A Strep |
| | Group B Strep Screen |
| | *C. difficile* Toxin |
| | Diphtheria |
| | Foodborne Pathogens (*B. cereus, C. perfringens, S. aureus*) |
| | Gonorrhea Culture:Incubated?☐yes ☐no |
| | Hrs. incubated:___ Add'l specimen codes:___ |
| | MRSA (rule out) |
| | VRE (rule out) |
| | **ENTERIC INFECTIONS** |
| | Campylobacter |
| | *E. coli* O157 typing |
| | Enteric Culture - Routine (Salmonella, Shigella, *E. coli* O157, Campylobacter) |
| | Salmonella typing |
| | Shigella typing |
| | *V. parahaemolyticus* |
| | Yersinia |
| | **REFERENCE MICROBIOLOGY** |
| | ABC'S (BIDS) #_____ |
| | Organism: _____ |
| | Bacteria Referred Culture for ID |
| | Specify: _____ |

| SPECIMEN CODE | SPECIAL BACTERIOLOGY |
|---|---|
| | Legionella Culture |
| | Leptospira |
| | Mycoplasma |
| | **MYCOBACTERIOLOGY/AFB/TB** |
| | AFB/TB Culture and Smear |
| | AFB/TB Referred Culture for ID |
| | *M. tuberculosis* Referred Culture for Genotyping |
| | Nucleic Acid Amplification Test for *M. tuberculosis* Complex (MTD) |
| | **PARASITOLOGY** |
| | Blood Parasites: |
| | Country visited outside US:_____ |
| | Ova & Parasites:Immigrant? ☐yes ☐no |
| | Cryptosporidum |
| | Cyclospora/Isospora |
| | Microsporidium |
| | Pinworm |
| | **VIRUS ISOLATION/CHLAMYDIA** |
| | Adenovirus* |
| | Arbovirus Panel (WNV, EEEV, SLEV) |
| | *Chlamydia trachomatis* |
| | Cytomegalovirus (CMV) |
| | Enterovirus (Inc. Echo & Coxsackie) |
| | Herpes Simplex Virus (Types 1 & 2) |
| | Influenza (Types A & B)* |
| | Parainfluenza (Types 1, 2 & 3)* |
| | Respiratory Syncytial Virus (RSV)* |
| | Varicella (VZV) |

Comments:

| SPECIMEN CODE | RESTRICTED TESTS |
|---|---|
| | Pre-approved submitters only |
| | *Chlamydia trachomatis*/GC NAAT |
| | *Chlamydia trachomatis* only/NAAT |
| | Norovirus ** (see comment on back) |
| | **OTHER TESTS FOR INFECTIOUS AGENTS** |
| | Test name: |

Prior arrangements have been made with the following DHMH Laboratories Administration employee:

SPECIMEN CODE:
PLACE CODE IN BOX NEXT TO TEST

B Blood
BW Bronchial Washing
CSF Cerebrospinal Fluid
CX Cervix/Endocervix
E Eye
F Feces
N Nasopharyngeal
P Penis
R Rectum
SP Sputum
T Throat
URE Urethra
UFV Urine (First Void)
UCC Urine (Clean Catch)
V Vagina
W Wound
O Other:

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

Must fill in the date specimen was collected.

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

**Write test name MERS-CoV & specimen sources**

**1. lower respiratory specimen: sputum, bronchoalveolar lavage, tracheal aspirate**
**2. upper respiratory specimen: nasopharyngeal & oropharyngeal swabs in VTM**
**3. stool**
**4. serum**

**For additional questions, please contact the Division of Molecular Biology Laboratory at (410)767-5819.**