

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 | <input type="checkbox"/> EH <input type="checkbox"/> FP <input type="checkbox"/> MTY/PN <input type="checkbox"/> NOD <input type="checkbox"/> STD <input type="checkbox"/> TB <input type="checkbox"/> CD <input type="checkbox"/> COR | | Patient SS # (last 4 digits): | | |
| | Health Care Provider | | Last name <input type="checkbox"/> SR <input type="checkbox"/> JR <input type="checkbox"/> Other: | | |
| | Address | | First Name M.I. | | |
| | City | County | Date of Birth (mm/dd/yyyy) / / | | |
| | State | Zip Code | Address | | |
| | Contact Name: | | City County | | |
| | Phone # | Fax # | State Zip Code | | |
| | Test Request Authorized by: | | | | |
| | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender M to F <input type="checkbox"/> Transgender F to M | | Ethnicity: Hispanic or Latino Origin? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White | | | | |
| MRN/Case # | DOC # | Outbreak # | Submitter Lab # | | |
| Date Collected: | Time Collected: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | Onset Date: ____/____/____ | | | |
| Reason for Test: <input type="checkbox"/> Screening <input type="checkbox"/> Diagnosis <input type="checkbox"/> Contact <input type="checkbox"/> Test of Cure <input type="checkbox"/> 2-3 Months Post Rx <input type="checkbox"/> Suspected Carrier <input type="checkbox"/> Isolate for ID <input type="checkbox"/> Release | | | | | |
| Therapy/Drug Treatment: <input type="checkbox"/> No <input type="checkbox"/> Yes Therapy/Drug Type: _____ Therapy/Drug Date: ____/____/____ | | | | | |
| ↓ SPECIMEN SOURCE CODE | | ↓ SPECIMEN SOURCE CODE | | ↓ SPECIMEN SOURCE CODE | |
| ↓ BACTERIOLOGY | | ↓ MYCOBACTERIOLOGY/AFB/TB | | ↓ SPECIAL BACTERIOLOGY | |
| Bacterial Culture - Routine | | AFB/TB Culture and Smear | | Legionella Culture | |
| Add'l Specimen Codes: ____ | | AFB/TB Referred Isolate for ID | | Leptospira | |
| <i>Bordetella pertussis</i> | | <i>M. tuberculosis</i> referred Isolate for genotyping | | Mycoplasma (Outbreak Investigation Only) | |
| Group A Strep | | Nuclear Acid Amplification Test for | | RESTRICTED TESTS Pre-approved submitters only | |
| Group B Strep Screen | | <i>M. tuberculosis</i> Complex (GeneXpert) | | | |
| <i>C. difficile</i> Toxin | | PARASITOLOGY | | <i>Chlamydia trachomatis</i> /GC NAAT | |
| Diphtheria | | Blood Parasites: _____ | | Norovirus** (See comment on reverse) | |
| Foodborne Pathogens | | Country visited outside US: | | QuantIFERON | |
| <i>(B. cereus, C. perfringens, S. aureus)</i> | | Ova & Parasites | | Incubation: Time began: ____ a.m./p.m. | |
| Gonorrhea Culture: | | Immigrant? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Time ended: ____ a.m./p.m. | |
| Incubated? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Cryptosporidium | | OTHER TESTS FOR INFECTIOUS AGENTS | |
| Hours Incubated: _____ | | Cyclospora/Isospora | | | |
| Add'l specimen Codes: ____ | | Microsporidium | | Test Name: _____ | |
| MRSA (rule out) | | Pinworm | | _____ | |
| VRE (rule out) | | VIRUS/CHLAMYDIA | | _____ | |
| ENTERIC INFECTIONS | | Adenovirus* | | Prior arrangements have been made with the | |
| Campylobacter | | <i>Chlamydia trachomatic</i> culture | | following MDH Labs Administration employee: | |
| <i>E. coli</i> 0157 typing/Shiga toxins | | Cytomegalovirus (CMV) | | _____ | |
| Enteric Culture - Routine | | Enterovirus (Includes Echo & Coxsackie) | | | |
| <i>(Salmonella, Shigella, E. coli</i> 0157, <i>Campylobacter)</i> | | Herpes Simplex Virus (Types 1 & 2) | | SPECIMEN SOURCE CODE | |
| Salmonella typing | | Influenza (Types A & B)* Rapid Flu Test: | | PLACE CODE IN BOX NEXT TO TEST | |
| Shigella typing | | Type: _____ | | B Blood SP Sputum | |
| <i>Vibrio</i> | | Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive | | BW Bronchial Washing T Throat | |
| Yersinia | | Patient admitted to hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No | | CSF Cerebrospinal Fluid URE Urethra | |
| REFERENCE MICROBIOLOGY | | Parainfluenza (Types 1, 2 & 3)* | | CX Cervix/Endocervix UFV Urine (1 st Void) | |
| ABC's (BIDS) # _____ | | Varicella (VZV) | | E Eye UCC Urine (Clean Catch) | |
| Organism: _____ | | *MAY INCLUDE RESPIRATORY SCREENING PANEL | | F Feces V Vagina | |
| Bacteria Referred Culture for ID | | Comments: | | N Nasopharynx/Nasal W Wound | |
| Specify: _____ | | _____ | | P Penis O Other: _____ | |
| _____ | | _____ | | R Rectum _____ | |