Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

Date: November 12, 2024

To: Medical Laboratory Directors

From: David Blythe, MD MPH DB
Director, Infectious Disease Bureau

Robert A. Myers, Ph.D. R.A.M.
Director, Laboratories Administration

Re: Submitting Specimens to the MDH Laboratory for Regulatory Compliance/Surveillance

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The Annotated Code of Maryland, Health General § 18-205 requires laboratories performing testing on specimens collected from Maryland residents to report laboratory evidence of agents responsible for communicable disease conditions to the Maryland Department of Health (MDH) and to promptly submit remnant pathogen positive clinical materials (specimens and isolates) from a subset of these conditions to the Maryland Department of Health Laboratory (MDH Lab) as specified in Code of Maryland Regulations (COMAR) 10.06.01.03. These regulations apply to both laboratories located in Maryland that are performing testing as well as any laboratories that test specimens from Maryland residents. For additional information, refer to the link below: https://health.maryland.gov/phpa/IDEHASharedDocuments/ReportableDisease_HCP.pdf

As specified in the reporting procedures (COMAR 10.06.01.04), MDH is providing and **requiring the mandatory** use of two MDH Laboratory test requisition forms (MDH 4676 Revised 09/2024 [Infectious Agents] & MDH 4677 Revised 9/2024 [Serology] or most current version on the MDH Lab webpage) to standardize and facilitate the submission of the required positive clinical materials to the public health laboratory. Both forms have a prominently designated box to be checked when submitting clinical materials for regulatory compliance or as part of a designated pathogen surveillance program (Refer to the attached examples of the MDH 4676 and MDH 4677 Test Requisition Forms for guidance on proper form completion).

Checking this box on the MDH Laboratory test forms along with the appropriate reportable test condition indicates that you are not ordering a test. Therefore, a result report will not be returned to the submitter and in lieu of a result report an acknowledgement of the receipt of the specimen will be sent.

If specimens are to be submitted for diagnostic purposes to MDH Laboratory, do not check this box. Complete the appropriate MDH Lab test request form in the CLIA compliant manner. Upon receipt, the submitted specimen(s) will be processed for testing and laboratory findings will be returned to the submitter.

Fillable PDF copies of the requisition forms are available on the home page of the MDH Laboratories website. Please visit our website (https://health.maryland.gov/laboratories/Pages/home.aspx) for more information regarding the logistical details of submitting specimens to the MDH Laboratory. You can also contact us at (443) 681-3800 for questions regarding submission of specimens for regulatory compliance or a surveillance program.

The specimens submitted for regulatory compliance to the MDH Laboratory for additional testing and characterization provide valuable insights into the transmission, prevalence and progression of the communicable diseases in our communities. We thank you for your cooperation and understanding.

STATE LAB

Example: Influenza Surveillance

Laboratories Administration MDH
...e • Baltimore, MD 21205
3-681-3800
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 **1) Health Care Provider -Facility location (REQUIRED)**

City County

State Zip Code

Contact

Phone **2) Test Request Authorized By (TRAB) – Name and credentials of ordering clinician/provider (REQUIRED)**

Test Request Authorized by

Patient SS # (last 4 digits)

Last Name **3) Patient's First and Last Name (REQUIRED)**

First Name M.I.

Date of Birth (mm/dd/yyyy) **4) Date of Birth (REQUIRED)**

Address **5) Patient 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

6) Patient Demographics

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

7) Date Collected (REQUIRED) | Time Collected: **8) Time (REQUIRED)** ☐ a.m. ☐ 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

- 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)*

10) REQUIRED

NP

- Influenza (Types A & B)*
  - POC Testing Method: ***Name assay method***
  - Result: ☐ Negative ☒ Positive infA ☐ Positive infB
  - Patient admitted to hospital? ☐ No ☒ Yes
  - Subtype (If applicable): ***H3***
- 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: _____

11) REQUIRED

☒ **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		
S	Stool Specimen		

12) REQUIRED

MDH 4676 REVISED 09/24

*** **A surveillance receipt acknowledgement will be returned in lieu of a test result.** ***

STATE LAB

Example: Enteric Surveillance

Laboratories Administration MDH
nd 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 **1) Health Care Provider -Facility location (REQUIRED)**

City County

State **2) Test Request Authorized By (TRAB) – Name and credentials of ordering clinician/provider (REQUIRED)**

Contact N

Phone # Fax #

Test Request Authorized by

Patient SS # (last 4 digits)

3) Patient's First and Last Name (REQUIRED)

Last Name ☐ SR ☐ JR ☐ Other

First Name M.I.

Date of Birth (mm/dd/yyyy) **4) Date of Birth (REQUIRED)**

Address **5) Patient 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 **6) Patient Demographics** ☐Native Hawaiian/Other Pacific Islander ☐ White

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

Date Collected: **7) Date Collected (REQUIRED)** Time Collected: **8) Time (REQUIRED)** ☐ a.m. ☐ 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

- 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

10) Test order and Specimen Source Code (REQUIRED)

M

VRE (rule out)

ENTERIC INFECTIONS

- S 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: _____

11) REQUIRED

[X] **Submitted For Regulatory Compliance and/or Surveillance**** (Test Result(s) Not Issued)

*** **SurveillanceProgram (If Applicable):** _____

**Must also mark a test condition

Client

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		

MDH 4676 REVISED 09/24

*** **A surveillance receipt acknowledgement will be returned in lieu of a test result.** ***

Example: Dengue IgM Surveillance

Use Only

Laboratories Administration MDH
more, MD 21205
300
gov/laboratories/
Robert A. Myers, Ph.D., Director

MARYLAND Department of Health

SEROLOGICAL TESTING

TYPE OR PRINT REQUIRED INFORMATION OR PLACE LABELS ON BOTH COPIES

☐ COR

1) Health Care Provider -Facility location (REQUIRED)

Address

City County

2) Test Request Authorized By (TRAB) –Name and credentials of ordering clinician/provider

Phone # Fax #

Test Request Authorized by

Patient SS # (last 4 digits):

Last Name Other:

3) Patient's First and Last Name (REQUIRED)

First Name M.I.

Date of Birth (mm/dd/yyyy) / /

4) Date of Birth (REQUIRED)

Address

City County

State

5) Patient Address (PREFERRED)

Sex: ☐ Male ☐ Female ☐ Transgender M to F ☐ Transgender F to M

Ethnicity: Hispanic or Latino Origin? ☐ Yes ☐ No

Race: ☐ American Indian/Alaska Native ☐ White

6) Patient Demographics (PREFFERRED)

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

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

Previous Test Done? ☐ No ☐ Yes Name of Test Date / / ☐ 1st ☐ 2nd ☐ 3rd State Lab Number:

Name of Test Date / / ☐ 1st ☐ 2nd ☐ 3rd State Lab Number:

Onset Date: / / Exposure Date: / / ☐ Clinical Illness/Symptoms:

SPECIMEN SOURCE CODE

Arbovirus Panels

MANDATORY: Symptoms, Onset Date, Collection Date Based on information provided, PCR and immunological assays will be performed.

Required Information. Check all that apply:

SYMPTOMS: ☐ Headache ☐ Fever ☐ Stiff Neck ☐ Altered Mental State ☐ Muscle Weakness ☐ Rash

Other

IMMUNIZATIONS: ☐ Yellow Fever ☐ Flavivirus

10) PREFERRED

IMMUNOCOMPROMISED? ☐ Yes ☐ No

ILLNESS FATAL? ☐ Yes ☐ No

☐ **Arbovirus Endemic Panel**

DIA... ☐ Meningitis ☐ Encephalitis ☐ Other

11) REQUIRED

S **Arbovirus Travel-Associated Panel**

TRAVEL HISTORY (Dates and Places) **(REQUIRED)**

	Aspergillus
	Chagas disease
	Chlamydia (*group antigen IgG*)
	Coxiella burnetii (*Q Fever*)
	Cryptococcus (antigen)
	Cytomegalovirus (*CMV*)
	Epstein-Barr Virus (*EBV*)
	Hepatitis A Screen (IgM Ab only, acute infection) Call Lab (*443-681-3889*) prior to submitting

SPECIMEN SOURCE CODE

	Hepatitis B Screen (*HBs antigen only*) Prenatal patient? ☐ Yes ☐ No
	*Hepatitis B Panel: (*HBsAg, HBsAb*)
	*Hepatitis B post vaccine(*HBsAb*)
	Hepatitis C screen (*HCV Ab only*)
	Herpes Simplex Virus (*HSV*) types 1&2
	Legionella
	Leptospira
	MMRV Immunity Screen: [Measles(Rubeola)* Mumps, Rubella, Varicella (Chickenpox) IgG Ab only]
	Mononucleosis – Infectious
	Mumps Immunity Screen*
	Mycoplasma
	Rabies (*RFFIT*) (*List vaccination dates above*)*
	Rubella Immunity Screen*
	Rubeola (*Measles*) Immunity Screen*
	Syphilis
	Tickborne Panel- Anaplasma, Babesia microti, Ehrlichia, Lyme Disease, **Powassan Virus, Rickettsia (Rocky Mountain Spotted Fever, Murine typhus), Tularemia
	**The results are used for EPIDEMIOLOGICAL purposes and a report will not be issued.
	Toxoplasma
	Varicella Immunity Screen
	VDRL (*CSF only*)
	CDC/Other Test(s) Add'l Specimen Codes

Prior arrangements have been made with the following MDH Lab Administration Employee:

12) REQUIRED Please Note Vaccination History Above

MUST ALSO MARK A TEST

X Submitted for Surveillance and/or Regulatory Compliance (Test Result(s)Report NOT ISSUED)

Surveillance Program (If Applicable):

SPECIMEN SOURCE CODE

RESTRICTED TEST
Pre-approved submitters ONLY.
Submit a separate specimen for HIV.
http://health.maryland.gov/laboratories/

☐ HIV

Country of Origin:

Rapid Test: ☐ Reactive ☐ Negative

Date: / /

Specimen stored refrigerated (2°- 8°C) after collection: ☐ Yes ☐ No

Specimen transported on Cold Packs: ☐ Yes ☐ No

Serum/ plasma stored frozen (≤ -20°C) after collection: ☐ Yes ☐ No

☐ HCV RNA

Centrifugation Time: : ___ a.m. ___ p.m.

Specimen Receipt Temperature (For MDH Lab Use Only)

°C

SPECIMEN SOURCE CODES PLACE CODE IN BOX NEXT TO TEST

B	**Blood Specimen** (5 ml)
CSF	**Cerebrospinal Fluid Samp...**
P	**Plasma Specimen**
S	**Serum Specimen** (1 ml per test)
U	**Urine Specimen**

13) REQUIRED

*** A surveillance receipt acknowledgement will be returned in lieu of a test result. ***