SUSPECT MERS-CoV SPECIMEN SUBMISSION GUIDELINES
MARYLAND DHMH LABORATORIES ADMINISTRATION
JUNE 25, 2013

I. ACCEPTABLE SPECIMENS
1. Lower Respiratory Specimens: Sputum, broncheoalveolar lavage, tracheal aspirate
2. Upper Respiratory Specimens: Nasopharyngeal and Oropharyngeal Swabs in viral transport media
3. Stool
4. Serum

II. SPECIMEN COLLECTION KIT INSTRUCTIONS
Local health departments can order the UTM specimen collection kit and leak-proof, screw cap by calling 410-767-6120 or by faxing a completed request form (http://dhmh.maryland.gov/laboratories/docs/Request%20Form.pdf) at 410-333-5019.

III. SPECIMEN COLLECTION
Source: Interim Guidelines for Collection, Processing and Transport of Clinical Specimens from Patients under Investigation for Middle East Respiratory Syndrome (MERS)
http://www.cdc.gov/coronavirus/mers/downloads/Interim-Guidelines-MERS-Collection-Processing-Transport.pdf.

1. Lower Respiratory Specimens
a. Sputum
Have the patient rinse the mouth with water and then expectorate deep cough sputum directly into a sterile, leak-proof, screw-cap sputum collection cup or sterile dry container.
b. Lower respiratory tract aspirates/washes (Broncheoalveolar lavage, tracheal aspirate)
Collect 2-3 mL into a sterile, leak-proof, screw-cap sputum collection cup or sterile dry container.

2. Upper Respiratory Samples: Nasopharyngeal (NPS) and Oropharyngeal swabs (OPS) in viral transport media (VTM).
Use only synthetic fiber swabs with plastic shafts. Do not use calcium alginate swabs or swabs with wooden shafts, as they may contain substances that inactivate some viruses and inhibit PCR testing. Place swabs immediately into sterile tubes containing 2-3 ml of viral transport media.

Nasopharyngeal swabs: Insert a swab into the nostril parallel to the palate. Leave the swab in place for a few seconds to absorb secretions. Swab both nostrils.

Oropharyngeal swabs: Swab the posterior pharynx, avoiding the tonsils and tongue.

3. Stool
Collect 2-5 grams of stool specimen (formed or liquid) in sterile, leak-proof, screw-cap.

4. Serum
Serum specimens should be collected during the acute stage of the disease, preferably during the first week after onset of illness, and again during convalescence, ≥ 3 weeks later.
Children and adults: Collect 1 tube (5-10 mL) of whole blood in a serum separator tube. Allow the blood to clot, centrifuge briefly, and separate sera into sterile tube container.
Infants: A minimum of 1 cc of whole blood is needed for testing of pediatric patients. If possible, collect 1 cc in an EDTA tube and in a serum separator tube. If only 1cc can be obtained, use a serum separator tube

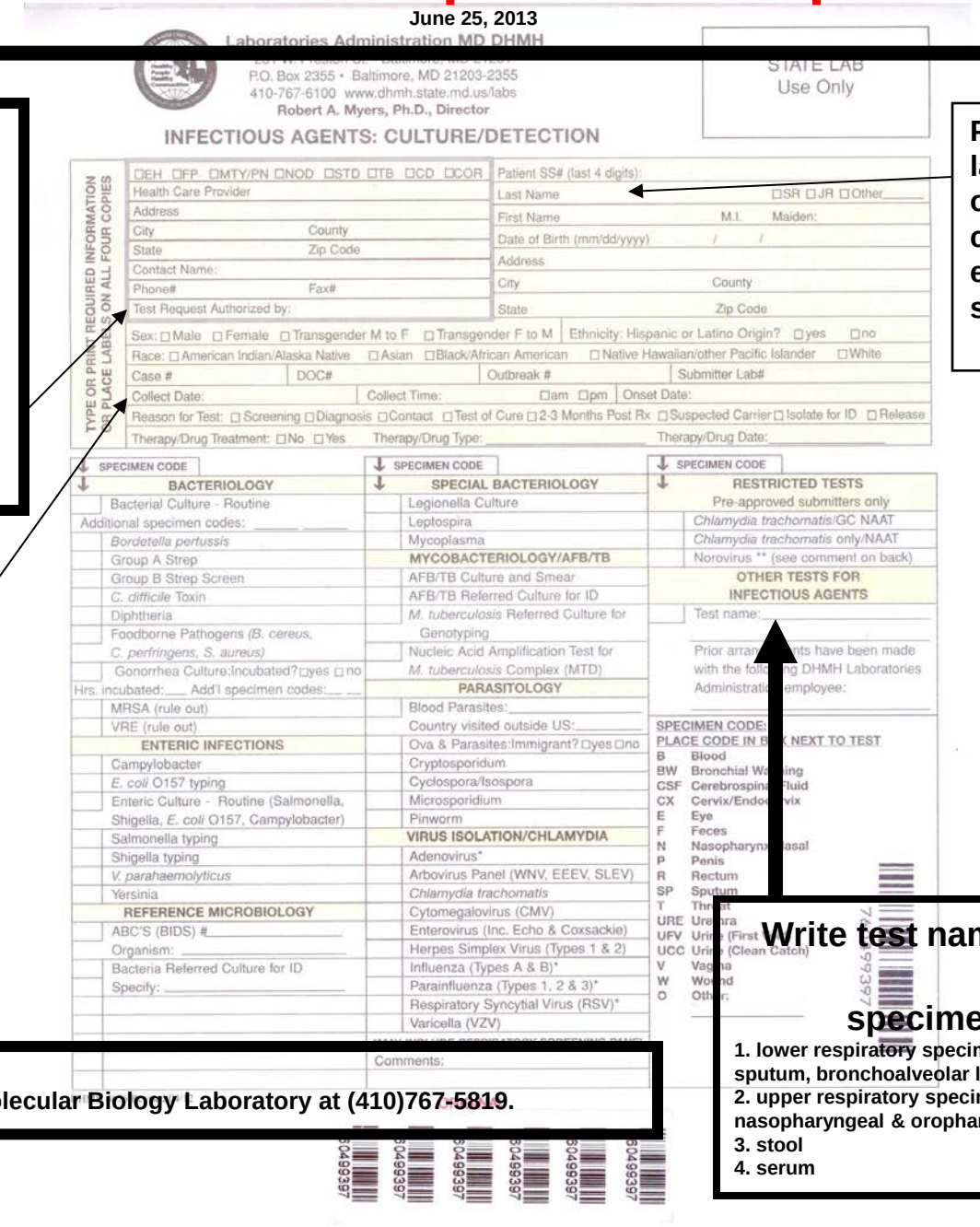
III. LABORATORY TEST REQUEST SLIP (INFECTIOUS AGENTS: CULTURE/DETECTION) INSTRUCTIONS
See the MERS-CoV Test Requisition Sample Form for guidance.

IV. PACKAGING AND SHIPPING
If you suspect a MERS CoV infection, please contact your Local Health Department for a review of the case. If testing is indicated the Local Health Department will make arrangements with the DHMH Laboratory for courier pick-up of specimens and expedited MERS CoV testing.

For questions or concerns, please contact the Division of Molecular Biology Laboratory at (410)767-5819 during normal business hours from 8:00AM - 4:30PM Monday through Friday.

For urgent inquiries after normal business hours, please contact the DHMH Lab emergency contact number at (410-925-3121).

MERS-CoV Test Requisition Sample Form



June 25, 2013

Laboratories Administration MD DHMH
P.O. Box 2355 • Baltimore, MD 21203-2355
410-767-6100 www.dhmh.state.md.us/labs
Robert A. Myers, Ph.D., Director

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.