

**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**



**INFECTIOUS AGENTS: CULTURE/DETECTION**

TESTING SECTION	<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.	
	County		Date of Birth (mm/dd/yyyy) / /	
TYPE OR PRINT REQ OR PLACE LABELS	Zip Code		Address	
	Fax #		City County	
	Test Request Authorized by:		State Zip Code	
	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 checked="" 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"/> Isolation 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	
	Bacteriology		↓ MYCOBACTERIOLOGY/AFB/TB	
	Add'l Specimen Codes		AFB/TB Culture and Smear	
Bordetella pertussis		AFB/TB Referred Isolate for ID		
Group A Strep		<i>M. tuberculosis</i> referred Isolate for genotyping		
Group B Strep Screen		Nuclear Acid Amplification Test for <i>M. tuberculosis</i> Complex (GeneXpert)		
<i>C. difficile</i> Toxin		PARASITOLOGY		
Diphtheria		Blood Parasites: _____		
Foodborne Pathogens		Country visited outside US: _____		
<i>(B. cereus, C. perfringens, S. aureus)</i>		Ova & Parasites		
Gonorrhea Culture:		Immigrant? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Incubated? Yes No		Cryptosporidium		
Hours Incubated: _____		Cyclospora/Isospora		
Add'l specimen Codes: _____		Microsporidium		
MRSA (rule out)		<input type="checkbox"/> Test Name: <u>ARLN C. auris colonization screening</u>		
VRE (rule out)		Prior arrangements have been made with the following MDH Labs Administration employee: <u>Liore Klein, liore.klein@maryland.gov</u>		
ENTERIC INFECTIONS		SPECIMEN SOURCE CODE		
Campylobacter		PLACE CODE IN BOX NEXT TO TEST		
<i>E. coli</i> O157 typing/Shiga toxins		B Blood SP Sputum		
Enteric Culture - Routine		BW Bronchial Washing T Throat		
<i>(Salmonella, Shigella, E. coli O157, Campylobacter)</i>		CSF Cerebrospinal Fluid URE Urethra		
Salmonella typing		CX Cervix/Endocervix UFV Urine (1st Void)		
Shigella typing		E Eye UCC Urine (Clean Catch)		
<i>Vibrio</i>		F Feeces V Vagina		
Yersinia		N Nasopharynx/Nasal W Wound		
REFERENCE MICROBIOLOGY		P Penis O Other: <u>Bilateral</u>		
ABC's (BIDS) # _____		R Rectum Axilla/Groin		
Organism: _____				
Bacteria Referred Culture for ID				
Specify: _____				

For ease of data entry, you can save a template with your facility information.

MDPHL requires two patient identifiers: Name and DOB.

Mark "Screening" as the reason for test.

Include outbreak number assigned to you by MDPHL.

To avoid processing delays, always include "ARLN C. auris colonization screening" and the ARLN Lab-Epi Coordinator, Liore Klein, as the point of contact.

DHMH 4676 Revised 05/17

Client