Instructions for Completing Test Request for Candida Speciation

Must complete the submitting entity information **(This is where reports will be sent)** & include name of practitioner requesting the test (TRAB: test request authorized by). Do not put the name of any MDH Lab staff for TRAB.

Complete the patient demographic information such as sex, MRN/Case #, Date collected, time collected & submitting Lab #.

Date collected is a required field

Patient's date of birth, first & last names must be on the specimen container and must exactly match the test request form

Write "**ARLN Candida Speciation**" to request testing and enter source code of the specimen/ isolate

Using this specimen source code, enter the code in the box next to the test name. If other, please identify the source.

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 SPECIMEN CONTAINERS

☐ EH ☐ FP ☐ MTY/PN ☐ NOD ☐ STD ☐ TB ☐ CD ☐ COR
Health Care Provider **TEST FACILITY**
Address **123 N. TEST FACILITY ROAD**
City **BALTIMORE** County **CITY**
State **MD** Zip Code **01234**
Contact Name: **JOE SHMO**
Phone # **111-111-1111** Fax # **111-111-1112**
Test Request Authorized by: **DR. TRAB, MD**

Patient SS # (last 4 digits):
Last name **DOE** ☐ SR ☐ JR ☐ Other:
First Name **JOHN** M.I.
Date of Birth (mm/dd/yyyy) **01 / 01 / 2000**
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
MRN/Case # **000002** DOC # Outbreak # Submitter Lab # **XYZ0123**
Date Collected: **10/20/2017** Time Collected: ☐ a.m. ☐ p.m. 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 SOURCE CODE ↓ BACTERIOLOGY

- ☐ Bacterial Culture - Routine
  Add'l 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
  Hours Incubated: _____
  Add'l specimen Codes: ____ ____ ____
- ☐ MRSA (rule out)
- ☐ VRE (rule out)

ENTERIC INFECTIONS

- ☐ Campylobacter
- ☐ *E. coli* 0157 typing/Shiga toxins
- ☐ Enteric Culture - Routine
  (Salmonella, Shigella, *E. coli* 0157, Campylobacter)
- ☐ Salmonella typing
- ☐ Shigella typing
- ☐ *Vibrio*
- ☐ Yersinia

REFERENCE MICROBIOLOGY

- ☐ ABC's (BIDS) # _____
- Organism: _____
- ☐ Bacteria Referred Culture for ID
  Specify: _____

↓ SPECIMEN SOURCE CODE ↓ MYCOBACTERIOLOGY/AFB/TB

- ☐ AFB/TB Culture and Smear
- ☐ AFB/TB Referred Isolate for ID
- ☐ *M. tuberculosis* referred Isolate for genotyping
- ☐ Nuclear Acid Amplification Test for *M. tuberculosis* Complex (GeneXpert)

PARASITOLOGY

- ☐ Blood Parasites: _____
- Country visited outside US:
- ☐ Ova & Parasites
  Immigrant? ☐ Yes ☐ No
- ☐ Cryptosporidium
- ☐ Cyclospora/Isospora
- ☐ Microsporidium
- ☐ Pinworm

VIRUS/CHLAMYDIA

- ☐ Adenovirus*
- ☐ *Chlamydia trachomatis* culture
- ☐ Cytomegalovirus (CMV)
- ☐ Enterovirus (Includes Echo & Coxsackie)
- ☐ Herpes Simplex Virus (Types 1 & 2)
- ☐ Influenza (Types A & B)* Rapid Flu Test:
  Type: _____
  Result: ☐ Negative ☐ Positive
  Patient admitted to hospital? ☐ Yes ☐ No
- ☐ Parainfluenza (Types 1, 2 & 3)*
- ☐ Varicella (VZV)

*MAY INCLUDE RESPIRATORY SCREENING PANEL

Comments:

↓ SPECIMEN SOURCE CODE ↓ SPECIAL BACTERIOLOGY

- ☐ Legionella Culture
- ☐ Leptospira
- ☐ Mycoplasma (Outbreak Investigation Only)

RESTRICTED TESTS
Pre-approved submitters only

- ☐ *Chlamydia trachomatis*/GC NAAT
- ☐ Norovirus** (See comment on reverse)
- ☐ QuantiFERON
  Incubation: Time began: _____a.m./p.m.
  Time ended: _____a.m./p.m.

OTHER TESTS FOR INFECTIOUS AGENTS

- O Test Name: ARLN CANDIDA SPECIATION

Prior arrangements have been made with the following MDH Labs Administration employee:
_____

SPECIMEN SOURCE CODE
PLACE CODE IN BOX NEXT TO TEST

B	Blood	SP	Sputum
BW	Bronchial Washing	T	Throat
CSF	Cerebrospinal Fluid	URE	Urethra
CX	Cervix/Endocervix	UFV	Urine (1st Void)
E	Eye	UCC	Urine (Clean Catch)
F	Feces	V	Vagina
N	Nasopharynx/Nasal	W	Wound
P	Penis	O	Other: GROIN
R	Rectum		

DHMH 4676 Revised 05/17

Client