MARYLAND
Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

Laboratories Administration
Robert A. Myers, Ph.D., Director
1770 Ashland Avenue
Baltimore, Maryland 21205

MEMORANDUM

To: Clinical Specimen Submission Facilities

From: Heather L. Peters, Manager, Accessioning Laboratory HLP

Through: Robert A. Myers, Ph.D., Director, Laboratories Administration RAM

Date: February 15, 2018

Re: Laboratory Requisition Requirements for Clinical Laboratory Specimens

The Maryland Department of Health (MDH) Laboratories Administration (LA) staff review all test request forms for completeness of the required information. When omissions are detected, the submitting facility must be contacted to obtain the missing information. As part of our Continuing Quality Assurance Program, we have compiled annual statistics in regards to improper submission of the LA's forms MDH 4677 (Serological Testing) and MDH 4676 (Infectious Agents). For calendar year 2017, the most common omissions were:

- missing collection date
- missing submitter information
- missing specimen source
- missing test request

The overall error rate was 1.0%. While we recognize that this is a relatively low number, it did require over 1000 phone calls and/or faxes reflecting a significant amount of time and effort spent by both our staff and yours to resolve the problems. In addition, turnaround time may have been adversely affected for the specimens involved.

Enclosed are sample forms with descriptions of all the minimally required information for the submission of clinical specimens. There may also be further "test specific" requirements. For these details, please consult the *Guide to Public Health Laboratory Services* located on our web site.
https://health.maryland.gov/laboratories/docs/Guide%20to%20PH%20Lab%20Serv%20v2.0.7%202017%20Guide%20Updated%2010-2017%20Final.pdf

Please share the enclosed examples of how to properly complete the MDH LA's test request forms with the appropriate staff and post in conspicuous locations to aide staff when completing the paperwork for your specimen submissions.

If you have any questions or would like details about the 2017 error/omission rate for your facility, please contact Susan Taylor at 443-681-3793 or susan.taylor@maryland.gov.

Thank you for your attention to this matter and for partnering with us to ensure accurate and timely test results.

Mandatory: Complete Health Care Provider Section.

Mandatory: Fill in TRAB box.

STATE LAB Use Only

Laboratories Administration MDH
1770 Ashland Ave • Baltimore, MD 21205
443-681-3800 http://health.maryland.gov/laboratories/
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MARYLAND Department of Health

INFECTIOUS AGENTS: CULTURE/DETECTION

Mandatory: Complete patient information section.

TYPE OR PRINT REQUIRED INFORMATION OR PLACE LABELS ON BOTH 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.

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

Address

City County

State Zip Code

Complete patient's sex, ethnicity, and race fields.

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 # DOC # Outbreak # Submitter Lab #

Date Collected: 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:

Complete specimen collection time field. (if applicable)

Mandatory: Collection date field must be completed in order for testing to be performed.

Complete MRN/Case# (if applicable)

Complete DOC# (if applicable)

↓ SPECIMEN SOURCE CODE

↓ BACTERIOLOGY

- *C. difficile* Toxin
- Diptheria
- Foodborne Pathogens (*B. cereus, C. perfringens, S. aureus*)
- Gonorrhea Culture: Incubated? ☐ Yes ☐ No; Hours Incubated: ____; Add'l specimen Codes: ____
- MRSA (rule out)
- *E. coli* 0157 typing/Shiga toxins
- Enteric Culture - Routine
- Vibrio
- Yersinia

REFERENCE MICROBIOLOGY

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

↓ SPECIMEN SOURCE CODE

↓ MYCOBACTERIOLOGY/AFB/TB

- re and Smear
- red Isolate for ID
- *M. tuberculosis* referred Isolate for genoty
- 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 trachomatic* culture
- Cytomegalovirus (CMV)
- Enterovirus (Includes Echo & Coxsackie)
- Herpes Simplex Virus (Types 1 & 2)
- N 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

↓

- Legionella Culture
- (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

- Test Name: ____

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

Mandatory: Order Test Using Specimen Source Code

Use the specimen code list to indicate specimen type submitted.

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: ____
R	Rectum		

Refer to page 2 for more detailed instructions.

Client

CLINIC CODES

EH- Employee Health
FP-Family Planning
MTY/PN-Maternity/Prenatal
NOD-Nurse of Day
STD/STI-Sexually Transmitted Disease/Infections
CD-Communicable Disease
COR-Correctional Facility
Do not mark a box if clinic type does not apply

COMPLETING FORM

Type or print legibly
Printed labels are recommended
Place printed labels on all copies of form
Press **firmly** –two part form
Collection date is required by law
Write collection time when appropriate, test specific

WRITE SPECIMEN CODE in box next to test

Specimens/samples can not be processed without a requested test.

NOROVIRUS –Outbreak Number Required

Appropriate for outbreak and epidemiological investigations **only**

A MDH Outbreak Number is required.

Contact your local health department for a MDH Outbreak Number

Questions/comments on the use of the specimen bags/storage/shipping or completing the form contact:
Questions/comments on the use of the specimen bags/storage/shipping or completing the form contact:
Accessioning Unit 443-681-3842 or 443-681-3793

To order specimen collection supplies contact:
Outfits Unit: 443-681-3777 or443-681-3776

For Specific Test Requirements Refer to:
Guide to Public Health Laboratory Services
Available on line:
https://health.maryland.gov/laboratories/Pages/Home.aspx

LABELING SPECIMENS/SAMPLES

Printed labels with all required patient information are recommended

Print patient name, date of birth
Print date and time the specimen was collected
DO NOT cover expiration date of collection container

Write specimen source on collection containers when collecting specimens from multiple sites/sources

PACKAGING SPECIMENS FOR TRANSPORT

Never place specimens with different temperature requirements in the same biobag

Use one (1) biobag per temperature requirement

Review test request form to ensure all test(s) have been marked

Verify all specimens have been labeled

Place folded request form(s) in outer pouch of biobag

Multiple specimens from the same patient with the same temperature requirements must be packaged together in one (1) biobag

URINE SPECIMENS – Refrigerate PACKAGING AND SHIPPING

Double bag all urine specimens

Urine specimens require absorbent towel in biobag with specimen (express excess air before sealing)

Place bagged urine specimen in second biobag with all refrigerated specimens from the same patient

Place folded test request form(s) in outer pouch of second bag

LAB USE ONLY

Mandatory: Complete Health Care Provider Section.

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Mandatory: Complete patient information section.

SEROLOGICAL TESTING

TYPE OR PRINT REQUIRED INFORMATION OR PLACE LABELS ON BOTH 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.

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

Address

City County

State Zip Code

Complete patient's sex, ethnicity, and race fields.

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 # DOC # Outbreak # Submitter Lab #

Date Collected: Time Collected: ☐ a.m. ☐ p.m. *Vaccination History ____ ____ ____ ____

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: _____

Complete specimen collection time field. (if applicable)

Mandatory: Collection date field must be completed in order for testing to be performed.

Complete MRN/Case# (if applicable)

Complete DOC# (if applicable)

↓ SPECIMEN SOURCE CODE

Required information, check all that apply:
DIAGNOSIS: ☐ Aseptic Meningitis ☐ Encephalitis ☐ Other

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

ILLNESS FATAL? ☐ Yes ☐ No

IMMUNOCOMPROMISED? ☐ Yes ☐ No

Use the specimen code list to indicate specimen type submitted.

Mandatory: Order Test Using Specimen Source Code

	Aspergillus
	Babesia microti
	Chagas disease
	Chlamydia (group antigen IgG)
	Coxiella burnetii (Q Fever)
	Cryptococca (antigen)
	Cytomegalovirus (CMV)
B	Ehrlichia
	Epstein-Barr Virus (EBV)
	Hepatitis A Screen (IgM Ab only, acute infection)
	Call Lab (443-6

↓ SPECIMEN SOURCE CODE

	(HBs antigen only)
	☐ Yes ☐ No
	(HBsAg, HBsAb)
	*Hepatitis B post vaccine (HBsAb)
	Hepatitis C screen (HCV Ab only)
	Herpes Simplex Virus (HSV) types 1&2
	Legionella
	Leptospira
	Lyme Disease
	*MMRV Immunity Screen: [Measles (Rubeola) Mumps, Rubella, Varicella, (Chickenpox) IgG Ab only]
	Mononucleosis – Infectious
	*Mumps Immunity Screen
	Mycoplasma
	Rocky Mountain Spotted Fever (RMSF)
	*Rabies (RFFIT) (*List vaccination dates above)
	*Rubella Immunity Screen
	*Rubeola (Measles) Immunity Screen
	Schistosoma
	Stronglyoides
	Syphilis – Previously treated? ☐ Yes ☐ No
	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:

*Please Note Vaccination History Above

↓ SPECIMEN S

►► LAVEN

globin Disorders

usion? (Last 4 months) ☐ Yes ☐ No

een? ☐ Yes ☐ No

Father of Baby Screen? ☐ Yes ☐ No

Guardian's Name if patient is a minor:

Name of Mother of "at risk" baby:

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

SPECIMEN SOURCE CODE:
PLACE CODE IN BOX NEXT TO TEST

B	**Blood** (5 ml)
CSF	**Cerebrospinal Fluid**
L	**Lavender Top Tube**
P	**Plasma**
S	**Serum** (1 ml per test)
U	**Urine**

MDH 4677 Revised 05/17

Refer to page 2 for more detailed instructions.

Client

CLINIC CODES

EH- Employee Health
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COMPLETING FORM

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Collection date is required by law
Write collection time when appropriate, test specific

WRITE SPECIMEN CODE in box next to test

Specimens/samples can not be processed without a requested test.

VACCINATION HISTORY

Appropriate for outbreak and epidemiological investigations **only**

A MDH Outbreak Number is required.

Contact your local health department for a MDH Outbreak Number

HIV TESTING

Include previous HIV Test information in the top section under Previous Test Done
Submit a separate specimen for HIV Testing when multiple tests are ordered on the same form

Questions/comments on the use of the specimen bags/storage/shipping or completing the form contact: Accessioning Unit 443-681-3842 or 443-681-3793

To order specimen collection supplies contact: Outfits Unit: 443-681-3777 or443-681-3776

For Specific Test Requirements Refer to: Guide to Public Health Laboratory Services Available on line: https://health.maryland.gov/laboratories/Pages/home.aspx

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