Laboratories Administration MD DHMH
201 W. Preston St. • Baltimore, MD 21201
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)

MAY INCLUDE RESPIRATORY SCREENING PANEL.

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	**Nasopharynx/Nasal**
P	**Penis**
R	**Rectum**
SP	**Sputum**
T	**Throat**
URE	**Urethra**
UFV	**Urine (First Void)**
UCC	**Urine (Clean Catch)**
V	**Vagina**
W	**Wound**
O	**Other:**

ORIGINAL