STATE LAB Use Only

Approved RMM 11/05/2020

Laboratories Administration MDH
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MARYLAND Department of Health

INFECTIOUS AGENTS: CULTURE/DETECTION

TYPE OR PRINT REQUIRED INFORMATION OR PLACE LABELS ON BOTH COPIES

☐ EH ☐ FP ☐ MTY/PN ☐ NOD ☐ STD ☐ TB ☐ CD ☐ COR

Health Care
Address
City
State
Contact Na
Phone #

MANDATORY - complete the entire Health Care Provider (Facility) section. Test results will be mailed to the address and fax listed here. Facility can use pre-printed labels for HCP and TRAB

Patient SS # (last 4 digits):
Last Name
First Name
Date of Birth (mm/dd/yyyy)

Complete patient's first, last name and DOB (REQUIRED), and other information

Address
City County
State Zip Code

Test Request Authorized by: MANDATORY - add name and credentials of ordering provider

Sex: ☐ Male ☐
Race: ☐ America

Complete patient's sex, ethnicity, and race fields

Ethnicity: Hispanic or Latino Origin? ☐ Yes ☐ No
☐ Native Hawaiian/Other Pacific Islander ☐ White

MRN/Case # | DOC # | Outbreak # | Submitter Lab #

Date Collected: MANDATORY | Time Collected: MANDATORY ☐ p.m. | Onset Date:

Onset date: For SYMPTOMATIC patients

Reason for Test: ☐ Screening ☐ Diagnosis ☐ Contact ☐ Test of Cure ☐ 2-3 Months Post Rx ☐ Suspected Carri

Therapy/Drug Treatment: ☐ No ☐ Yes Therapy/Drug Type:

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)
  (B. cereus, C. perfringens, S. aureus)
- ☐ Gonorrhea Culture:
  Incubated? ☐ Yes ☐ No
  Hours Incubated: _____
  Add'l Specimen Codes: _____ _____ _____
- ☐ Gonorrhea Culture:
  Incubated? ☐ Yes ☐ No
  Hours Incubated: _____
  Add'l Specimen Codes: _____ _____ _____
- ☐ MRSA (rule out)
- ☐ VRE (rule out)

For FLU testing: Complete influenza questions for symptomatic patients. Indicate DIAGNOSTICS or SURVEILLANCE under "Comments" section below. Flu specimens for DIAGNOSTICS will be tested for COVID-19 and REPORTED. Surveillance does not receive any reports.

REFERENCE MICROBIOLOGY

- ☐ ABC's (BIDS) #

Indicate if patient previously positive for COVID-19 by NAAT or PCR test

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
- ☐ Cry
- ☐ Cyc
- ☐ Mic
- ☐ Pin

Mandatory: Write the Specimen Source Code in the box next to the test name. (e.g. "T" for Throat and "N" for Nasopharynx/ Nasal).

- ☐ Ade
- ☐ *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)*
- ☐ Respiratory Syncytial Virus (RSV)*
- ☐ VARICELLA (VZV)

*MAY INCLUDE RESPIRATORY SCREENING PANEL

Comments: ← COMMENT section

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

N For COVID-19 and or COVID-19/FLU testing - must indicate SYPMTOMATIC or ASYMPTOMATIC
Indicate priority level if known

Note Name of Lab Personnel or Epidemiologist Here

SPECIMEN SOURCE CODES
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		