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 COPIES

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

| Provider | Patient |
|---|---|
| Heath Care Provider | Patient SS # (last 4 digits): |
| Address | Last Name ☐ SR ☐ JR ☐ Other: |
| City  County | First Name  M.I. |
| State  Zip Code | Date of Birth (mm/dd/yyyy)  /  / |
| Contact Name: | Address |
| Phone #  Fax # | City  County |
| Test Request Authorized by: | 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 # — 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:______________________________ 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* O157 typing/Shiga toxins
- ☐ Enteric Culture - Routine
  (Salmonella, Shigella, *E. coli* O157, 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)*
- ☐ Respiratory Syncytial Virus (RSV)*
- ☐ 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

- ☐ Test Name: ______________________________
  ____________________________________

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

____________________________________

**SPECIMEN SOURCE CODES**

**PLACE CODE IN BOX NEXT TO TEST**

| Code | Source | Code | Source |
|---|---|---|---|
| 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 | | _________ |

## 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
Please place labels on all copies of form
**Print or type the name of the person Authorized to order test(s)** (this may be added to the pre-printed label).
Press **firmly** – two part form
**Collection date and time are required by Law.**
**WRITE SPECIMEN CODE in box next to test**

***Specimen/samples cannot 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:**
**Accessioning Unit 443-681-3842 or 443-681-3793**

**To order collection kits and/or specimen collection supplies, contact:**
**Outfit Unit 443-681-3777, Fax 443-681-3850 or**
**E-mail mdlabs.outfits@maryland.gov**

**For Specific Test Requirements Refer to:**
**"Guide to Public Health Laboratory Services"**
**Available online: mdh.maryland.gov/laboratories**

## 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 the collection container(s).**

## PACKAGING SPECIMENS FOR TRANSPORT

**Never place specimens with different temperature requirements in the same bio-bag.**

Use one (1) bio-bag 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 the outer pouch of bio-bag.

Multiple specimens from the same patient with the same temperature requirements must be packaged together in one (1) bio-bag.

## URINE SPECIMENS – Refrigerate PACKAGING AND SHIPPING

**Double bag all urine specimens.**

Urine specimens require absorbent towel in bio-bag with specimen (express excess air before sealing).

Place bagged urine specimen in second bio-bag with all refrigerated specimens from the same patient.

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