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

Hea… 1)Health Care Provider - Facility location **(REQUIRED)**
Address
City 2)Test Request Authorized By (TRAB) – Name and credentials of ordering clinician/provider **(REQUIRED)**
State Zip Code
C… ***Test results will only be returned to the TRAB at the address and facsimile provided***
Phone #
Test Request Authorized by:

Patient SS # (last 4 digits):
Last Name ☐ SR ☐ JR ☐ Other:
First Name 3)Patient's First and Last Name **(REQUIRED)**
Date of Birth (mm/dd/yyyy) / /
Address 4)Date of Birth **(REQUIRED)**
City 5)Complete address
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
6)Complete patient demographics

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

Date Collected 7)Date Collected **(REQUIRED)** | Time Collected: 8)Time Collected **(REQUIRED)** | Onset Date: 9)Onset Date – If symptomatic

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)
- ☐ 10a)Test Requested/Specimen Source **(REQUIRED)**
  Type:_____
  -For Flu/COVID combo PCR testing
  Pa… (Diagnostic OR Surveillance). ☐ No
- ☐ Parainfluenza (Types 1, 2 & 3)*
- ☐ Respiratory Syncytial Virus (RSV)*
- ☐ VARICELLA (VZV)

*MAY INCL… DE RESPIRATORY SCREEN

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

10b)Test Requested/Specimen Source
☐ Test Name: _____ **(REQUIRED)**

-For COVID ONLY PCR testing (write COVID) (Diagnostic OR Surveillance).
Prior arrangements have been made with the
-For NON Flu/COVID Respiratory ONLY PCR testing (write NIRV). (Surveillance ONLY).
NIRV testing will includes: adenovirus, rhinovirus, RSV, HMPV, and parainfluenza

SPECIMEN SOURCE C… 1/2/3

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
		W	Wound
		O	Other: _____

11)COMMENTS: Indicate the following:
-Submission reason – Diagnostic OR Surveillance (Diagnostic submission will receive reports, surveillance will not).
-Previous results – Patient test result for Flu, COVID, etc.; including test (i.e PCR, rapid, etc).
-Patient condition – SYMPTOMATIC or ASYMPTOMATIC.

Client