

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



INFECTIOUS AGENTS: CULTURE/DETECTION

TYPE OR PRINT REQUIRED INFORMATION OR PLACE LABELS ON BOTH COPIES	<input type="checkbox"/> EH <input type="checkbox"/> FP <input type="checkbox"/> MTY/PN <input type="checkbox"/> NOD <input type="checkbox"/> STD <input type="checkbox"/> TB <input type="checkbox"/> CD <input type="checkbox"/> COR		Patient SS # (last 4 digits):		
	Health Care Provider		Last Name <input type="checkbox"/> SR <input type="checkbox"/> JR <input type="checkbox"/> Other:		
	Address		First Name M.I.		
	City	County	Date of Birth (mm/dd/yyyy) / /		
	State	Zip Code	Address		
	Contact Name:		City County		
	Phone #	Fax #	State Zip Code		
	Test Request Authorized by:				
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender M to F <input type="checkbox"/> Transgender F to M		Ethnicity: Hispanic or Latino Origin? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White				
MRN/Case #	DOC #	Outbreak #	Submitter Lab #		
Date Collected:	Time Collected:	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Onset Date: ____/____/____		
Reason for Test: <input type="checkbox"/> Screening <input type="checkbox"/> Diagnosis <input type="checkbox"/> Contact <input type="checkbox"/> Test of Cure <input type="checkbox"/> 2-3 Months Post Rx <input type="checkbox"/> Suspected Carrier <input type="checkbox"/> Isolate for ID <input type="checkbox"/> Release					
Therapy/Drug Treatment: <input type="checkbox"/> No <input type="checkbox"/> Yes Therapy/Drug Type: _____ Therapy/Drug Date: ____/____/____					
SPECIMEN SOURCE CODE		SPECIMEN SOURCE CODE		SPECIMEN SOURCE CODE	
BACTERIOLOGY		MYCOBACTERIOLOGY/AFB/TB		SPECIAL BACTERIOLOGY	
Bacterial Culture - Routine		AFB/TB Culture and Smear		Legionella Culture	
Add'l Specimen Codes: ____		AFB/TB Referred Isolate for ID		Leptospira	
<i>Bordetella pertussis</i>		<i>M. tuberculosis</i> referred Isolate for genotyping		Mycoplasma (Outbreak Investigation Only)	
Group A Strep		Nuclear Acid Amplification Test for		RESTRICTED TESTS Pre-approved submitters only	
Group B Strep Screen		<i>M. tuberculosis</i> Complex (GeneXpert)			
<i>C. difficile</i> Toxin		PARASITOLOGY		<i>Chlamydia trachomatis</i> /GC NAAT	
Diphtheria		Blood Parasites: _____		**Norovirus (See comment on reverse)	
Foodborne Pathogens		Country visited outside US:		QuantIFERON	
<i>(B. cereus, C. perfringens, S. aureus)</i>		Ova & Parasites		Incubation: Time began: ____ a.m./p.m.	
Gonorrhea Culture:		Immigrant? <input type="checkbox"/> Yes <input type="checkbox"/> No		Time ended: ____ a.m./p.m.	
Incubated? <input type="checkbox"/> Yes <input type="checkbox"/> No		Cryptosporidium		OTHER TESTS FOR INFECTIOUS AGENTS	
Hours Incubated: _____		Cyclospora/Isospora			
Add'l specimen Codes: ____		Microsporidium			
MRSA (rule out)		Pinworm			
VRE (rule out)		VIRUS/CHLAMYDIA		Test Name: _____ _____ Prior arrangements have been made with the following MDH Labs Administration employee: _____	
ENTERIC INFECTIONS		Adenovirus*			
Campylobacter		<i>Chlamydia trachomatis</i> culture			
<i>E. coli</i> O157 typing/Shiga toxins		Cytomegalovirus (CMV)			
Enteric Culture - Routine		Enterovirus (Includes Echo & Coxsackie)			
<i>(Salmonella, Shigella, E. coli O157, Campylobacter)</i>		Herpes Simplex Virus (Types 1 & 2)			
Salmonella typing		Influenza (Types A & B)* Rapid Flu Test:			
Shigella typing		Type: _____			
<i>Vibrio</i>		Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive			
Yersinia		Patient admitted to hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No			
REFERENCE MICROBIOLOGY		Parainfluenza (Types 1, 2 & 3)*		SPECIMEN SOURCE CODES PLACE CODE IN BOX NEXT TO TEST	
ABC's (BIDS) # _____		Respiratory Syncytial Virus (RSV)*			
Organism: _____		VARICELLA (VZV)			
Bacteria Referred Culture for ID		*MAY INCLUDE RESPIRATORY SCREENING PANEL			
Specify: _____		Comments: _____			
				B Blood SP Sputum BW Bronchial Washing T Throat CSF Cerebrospinal Fluid URE Urethra CX Cervix/Endocervix UFV Urine (1 st Void) E Eye UCC Urine (Clean Catch) F Feces V Vagina N Nasopharynx/Nasal W Wound P Penis O Other: _____ R Rectum	