



MICROBIOLOGY LABORATORY SPECIMEN SUBMISSION FORM

PATIENT INFORMATION

PATIENT ID (Chart #, etc.)		
LAST NAME	FIRST NAME	MI
DATE OF BIRTH	SS# (last 4 only, optional)	
COUNTY OF RESIDENCE	SEX <input type="checkbox"/> Female <input type="checkbox"/> Male	
STREET ADDRESS		
CITY	STATE	ZIP
PATIENT PHONE NO. (optional)		

DATE OF COLLECTION:

SITE/SOURCE OF SPECIMEN:

<input type="checkbox"/> Blood	<input type="checkbox"/> Sputum
<input type="checkbox"/> Cellulose tape mount	<input type="checkbox"/> Sputum, induced
<input type="checkbox"/> CSF	<input type="checkbox"/> Stool
<input type="checkbox"/> Nasopharyngeal	<input type="checkbox"/> Stool, bloody
<input type="checkbox"/> Rectal	<input type="checkbox"/> Throat
<input type="checkbox"/> Serum	<input type="checkbox"/> Urethra
<input type="checkbox"/> Serum, acute	<input type="checkbox"/> Urine
<input type="checkbox"/> Serum, convalescent	
<input type="checkbox"/> Wound	Location:
<input type="checkbox"/> Bronchial	Specify:
<input type="checkbox"/> Tissue	Specify:
<input type="checkbox"/> Fluid	Specify:
<input type="checkbox"/> Other	Specify:

SUBMITTER INFORMATION

FACILITY NAME		
MAILING ADDRESS		
CITY	STATE	ZIP
COUNTY		
ATTENTION TO		
PHONE NO.		
FAX NO.		

TEST(S) REQUESTED:

BACTERIOLOGY	MYCOBACTERIOLOGY
<input type="checkbox"/> Referred Culture	<input type="checkbox"/> Culture/Smear <small>C</small>
<input type="checkbox"/> Pertussis culture / PCR	<input type="checkbox"/> TB ID/Confirmation <small>R</small>
<input type="checkbox"/> Enteric (stool in Cary-Blair)	<input type="checkbox"/> MOTT Identification <small>R</small>
<input type="checkbox"/> Gonorrhea culture	Suspected Organism:
<input type="checkbox"/> Gonorrhea smear	Date growth appeared:
<input type="checkbox"/> Unknown bacteriology ID	Patient taking TB drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No
Suspected Organism (s):	Date Started:

VIROLOGY

<input type="checkbox"/> Influenza RT-PCR
Submitted for:
<input type="checkbox"/> Surveillance
<input type="checkbox"/> Sentinel Provider / Hosp
<input type="checkbox"/> Other * (note in Comments)
<input type="checkbox"/> Outbreak
If outbreak . . .
<input type="checkbox"/> School
<input type="checkbox"/> Nursing Home
<input type="checkbox"/> Other
County: _____
Was sample frozen? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Norovirus RT-PCR** EPI Contact Name:
<input type="checkbox"/> Arbovirus, human (Date of Symptom Onset: _____)

Skin Test <input type="checkbox"/> POS (+) <input type="checkbox"/> NEG (-)
Chest X-ray <input type="checkbox"/> Abnormal <input type="checkbox"/> Normal
Contact to TB patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Refrigerated? <input type="checkbox"/> Yes <input type="checkbox"/> No

PARASITOLOGY
<input type="checkbox"/> Fecal Parasite Exam 10% formalin
<input type="checkbox"/> Fecal Parasite Exam PVA
<input type="checkbox"/> Pinworm Exam

* "Others" MUST be approved by DIDE.

** Norovirus testing performed on outbreak specimens ONLY.

COMMENTS:

OLS USE ONLY	
<input type="checkbox"/> UNSAT Reason:	ACC:
<input type="checkbox"/> UNRELIABLE Reason:	DE:
<input type="checkbox"/> SATISFACTORY	CKD: