



**MICROBIOLOGY LABORATORY SPECIMEN SUBMISSION FORM**

**PATIENT INFORMATION**

PATIENT ID (Chart #, etc.) <span style="float: right;">MAX. 17 CHARACTERS</span>		
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 <span style="float: right;">c</span>
<input type="checkbox"/> Pertussis culture / PCR	<input type="checkbox"/> TB ID/Confirmation <span style="float: right;">R</span>
<input type="checkbox"/> Enteric (stool in Cary-Blair)	<input type="checkbox"/> MOTT Identification <span style="float: right;">R</span>
<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:
	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

**VIROLOGY**

Influenza RT-PCR  
 Submitted for:  
 Surveillance (Sentinel)  
 Other (note in Comments)  
 Outbreak  
 If outbreak . . .  
 School  
 Nursing Home  
 Other

**OUTBREAK NUMBER \***  
(REQUIRED FOR OUTBREAKS)

Respiratory Virus Panel\*\*

Was sample frozen?  Yes  No

Norovirus RT-PCR\*\*

EPI Contact Name:

**PARASITOLOGY**

Fecal Parasite Exam  
 10% formalin  
 Fecal Parasite Exam  
 PVA  
 Pinworm Exam

**SENDOUT**

Referred Culture

**COMMENTS:**

**OLS USE ONLY**

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

\* To obtain outbreak number, contact Division of Infectious Disease Epidemiology.  
 \*\* Testing performed on outbreak specimens ONLY.