



**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 <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/smear	Suspected Organism:
<input type="checkbox"/> Unknown bacteriology ID	Date growth appeared:
Suspected Organism (s):	Patient taking TB drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No
	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**

<input type="checkbox"/> Influenza RT-PCR
Submitted for:
<input type="checkbox"/> Surveillance (Sentinel)
<input type="checkbox"/> Other (note in Comments)
<input type="checkbox"/> Outbreak
If outbreak . . .
<input type="checkbox"/> School
<input type="checkbox"/> Nursing Home/LTCF
<input type="checkbox"/> Other
<input type="checkbox"/> Respiratory Pathogen Panel ***
Was specimen pre-screened for presence of Influenza? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Norovirus RT-PCR ***
<input type="checkbox"/> GI Pathogen Panel ***

**COMMENTS:**

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**PARASITOLOGY**

<input type="checkbox"/> Fecal Parasite Exam (10% formalin)
<input type="checkbox"/> Pinworm Exam (cellulose tape mount)

**SENDOUT**

<input type="checkbox"/> Referred Culture/ID
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**OLS USE ONLY**

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

**OUTBREAK NUMBER**

(REQUIRED FOR OUTBREAKS - OBTAIN FROM DIDE)
CONTACT NAME: _____

\*\*\* Testing performed on outbreak specimens ONLY.

DIDE = Division of Infectious Disease Epi