## MICROBIOLOGY TEST REQUEST FORM

**UNIFIED STATE LABORATORIES: PUBLIC HEALTH**

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TAYLORSVILLE, UTAH 84129
TELEPHONE: (801) 965-2400, (801) 965-2561
FAX: (801) 965-2551
http://health.utah.gov/lab/microbiology

**FOR USLPH USE ONLY**

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**DATE STAMP**

**TESTING WILL NOT BE PERFORMED UNLESS FORM IS COMPLETELY FILLED OUT. PLEASE PRINT CLEARLY FOR ACCURACY.**

### PATIENT INFORMATION

<table>
<thead>
<tr>
<th>SAMPLE STATE OF ORIGIN:</th>
<th>UTAH PATIENT/SAMPLE COUNTY OF ORIGIN:</th>
<th>ZIP CODE:</th>
<th>DATE OF BIRTH (mm/dd/yyyy)</th>
<th>AGE</th>
<th>SEX</th>
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### PATIENT NAME (Last, First):

- **ETHNICITY**
  - [ ] Hispanic
  - [ ] White
  - [ ] Black or African American
  - [ ] American Indian or Alaska Native
  - [ ] Non-Hispanic
  - [ ] Asian
  - [ ] Native Hawaiian or other Pacific Islander

### PROVIDER INFORMATION

- **Provider Code:**
- **Physician:**
- **Provider Phone:** (mm/dd/yyyy)
- **Provider Email:**
- **Secure Fax #:**
- **Time:**

### SPECIMEN SOURCE/SITE (CHOOSE 1):

- [ ] Blood
- [ ] Bronchoalveolar lavage
- [ ] Bronchial aspirate
- [ ] Bronchial wash
- [ ] Cerebrospinal fluid
- [ ] Cervix
- [ ] Endotracheal aspirate
- [ ] Endotracheal wash

### BACTERIOLOGY/TUBERCULOSIS TESTS

- [ ] Bacterial Culture
- [ ] Mycobacterial culture
- [ ] Mycobacterial referral

### IMMUNOLOGY / VIROLOGY TESTS

- [ ] Measles
- [ ] Chlamydia and Gonorrhea by NAAT
- [ ] Symptomatic
- [ ] Pregnancy test only visit
- [ ] Positive CT in the past 12 months
- [ ] Client meets screening criteria
- [ ] New partner in the last 60 days
- [ ] Immunoassay
- [ ] Other (specify): ___________

### BIOTERRORISM TESTS

- [ ] Bacillus anthracis
- [ ] Brucella spp.
- [ ] Brucella spp. Microagglutination
- [ ] Burkholderia mallei/pseudomallei
- [ ] Clostridium botulinum culture & toxin
- [ ] Coxiella burnetii
- [ ] Francisella tularensis
- [ ] F. tularensis microagglutination
- [ ] Orthopox virus
- [ ] Varicella zoster virus
- [ ] Yersinia pestis
- [ ] Yersinia pestis hemagglutination

### ADDITIONAL INFORMATION: MARK ALL THAT APPLY

- [ ] Acute Serum (mm/dd/yyyy)
- [ ] Convalescent Serum (mm/dd/yyyy)
- [ ] Presumptive ID:
- [ ] Other (specify): ___________

### COMMENTS:

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[Fill in additional comments as needed.]