

MICROBIOLOGY TEST REQUEST FORM

UNIFIED STATE LABORATORIES: PUBLIC HEALTH
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FOR USLPH USE ONLY
LAB#

DATE STAMP

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

PATIENT INFORMATION:

SAMPLE STATE OF ORIGIN:	UTAH PATIENT/SAMPLE COUNTY OF ORIGIN:	ZIP CODE:	DATE OF BIRTH (mm/dd/yyyy)	AGE	SEX M F
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PATIENT NAME (Last, First): Your patient ID number if you would like it included on the report for your records.

PATIENT ID #	ETHNICITY	RACE
	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native

PROVIDER INFORMATION

Provider Code: _____

Physician: Enter if available for TB program. _____

Provider Phone: _____

Provider Email: _____

Secure Fax #: _____

SPECIMEN COLLECTION DATE AND TIME

(mm/dd/yy) _____ / _____ / _____

Time: _____

SPECIMEN SOURCE/SITE (CHOOSE 1):

<input type="checkbox"/> Blood	<input type="checkbox"/> Environmental (specify): _____	<input type="checkbox"/> Plasma	<input type="checkbox"/> Throat swab
<input type="checkbox"/> Bronchoalveolar lavage	<input type="checkbox"/> Fluid (specify): _____	<input type="checkbox"/> Rectum	<input type="checkbox"/> Tissue (specify): _____
<input type="checkbox"/> Bronchial aspirate	<input type="checkbox"/> Food (specify): _____	<input type="checkbox"/> Scab	<input type="checkbox"/> Tracheal aspirate
<input type="checkbox"/> Bronchial wash	<input type="checkbox"/> Isolate (source): _____	<input type="checkbox"/> Serum	<input type="checkbox"/> Urethra
<input type="checkbox"/> Cerebrospinal Fluid	<input type="checkbox"/> Lesion (site): _____	<input type="checkbox"/> Skin	<input type="checkbox"/> Urine
<input type="checkbox"/> Cervix	<input type="checkbox"/> Nasal (aspirate /swab / wash)	<input checked="" type="checkbox"/> Sputum (natural induced)	<input type="checkbox"/> Vagina
<input type="checkbox"/> Endotracheal aspirate	<input type="checkbox"/> Nasopharyngeal swab	<input type="checkbox"/> Swab (specify site): _____	<input type="checkbox"/> Vomitus
<input type="checkbox"/> Endotracheal wash	<input type="checkbox"/> Nasopharyngeal-throat swab	<input type="checkbox"/> Stool	<input type="checkbox"/> Wound/Abcess
			<input type="checkbox"/> Other (specify): _____

BACTERIOLOGY/TUBERCULOSIS TESTS

Bacterial Culture

Bacterial ID / Referral

Presumptive ID: _____

Mycobacterial culture

Mycobacterial referral

Presumptive ID: _____

Other (specify): _____

IMMUNOLOGY / VIROLOGY TESTS

Chlamydia and Gonorrhea by NAAT

Patient request

IUD insertion

Cervical friability

Mucopus

PID

Urethritis

Colorado tick fever

Cytomegalovirus

HBsAb (antibody)

HBsAg (antigen)

HCVAb (antibody)

HIV EIA

HIV specimen required information

Repeat testing of reactive

Rapid test Reactive confirmation

Hantavirus (Sin Nombre)

Herpes simplex virus with typing

Influenza A & B virus PCR (with subtyping)

Hospitalized w/ Influenza-like illness

Sentinel site

Other (i.e., cluster investigation)

Cluster location: _____

Other reason for testing: _____

Measles

Mumps

QuantiFERON-TB Gold

QuantiFERON specimen required information

Incubation start time _____ Blood draw date/time: _____

Incubation end time _____ Signature: _____

Incubation at 37°C completed? YES NO

BIOTERRORISM TESTS

(Notify Lab before submitting)

Bacillus anthracis

Brucella spp.

Brucella spp. Microagglutination

Burkholderia mallei/pseudomallei

Clostridium botulinum culture & toxin

Coxiella burnetii

Francisella tularensis

F. tularensis microagglutination

Orthopox virus

Vaccinia virus

Varicella zoster virus

Variola virus

Yersinia pestis

Yersinia pestis hemagglutination

Other (specify): _____

Syphilis IgG EIA

Syphilis specimen required information

Previous positive RPR

Previous positive IgG EIA

Previous positive FTA/TPPA

Varicella zoster virus

Virus identification

Virus suspected: _____

West Nile virus IgM (Human)

ADDITIONAL INFORMATION: MARK ALL THAT APPLY

<input type="checkbox"/> Acute Serum (mm/dd/yyyy) _____ / _____ / _____	<input type="checkbox"/> Disease suspected: _____	<input type="checkbox"/> Exposure
<input type="checkbox"/> Convalescent Serum (mm/dd/yyyy) _____ / _____ / _____	<input type="checkbox"/> Employee medical screen	<input type="checkbox"/> Work related
<input type="checkbox"/> Presumptive ID: _____	<input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Pre-natal / Perinatal

COMMENTS:
