COMMONWEALTH OF VIRGINIA – DEPARTMENT OF GENERAL SERVICES
Division of Consolidated Laboratory Services
600 N 5th St. Richmond, Va. 23219

Clinical Microbiology/Virology Request Form

Patient Information (Please Print)

Name ______________________________ DOB ____/____/______ (mm dd yyyy) Age_______ ○M ○F
Last First Middle Initial

Pt Address____________________ City_____________, State________ Zip Code ______________

City/County of Residence______________________

Medical Record/Chart/Accession#________________ Patient ID________________

Marital Status: ○ single ○ married ○ separated ○ divorced ○ widowed ○ unknown

Race: ○ Black ○ White ○ Asian ○ AI/AN ○NH/PI ○ Other _____________ **Ethnicity:** ○ Hispanic/Latino ○ Not-Hispanic/Latino

(check all that apply)

Submitter Information

Submitter Code # ______________ Site code__________ FIPS code_____________

Send Report to:

Submitter ______________________________ Submitter Phone #______-______-__________
(Name of Health Dept, Hospital &/or private Clinician)

Submitter Address______________________ City ______________, State _______ Zip code____________

Attending Clinician______________________

Attending Clinician Phone # ________-________-________

District or PH Contact______________________

District or PH Contact Phone # ______-________-_________

Site Type

○ STD	○ ATS	○ DCJ	○FP	○ GYN	○ Priv Phys
○ OB/prenatal care	○ AHC	○ Field	○ IMM	○ Job Corp	○ Peds
○ TB	○ GMC	○ CHC	○ DTC	○ Refugee	○ SOI
○ Hospital	○ OCME	○ Student HC	○ Other _______________		

Patient Medical History

Disease suspected/Diagnosed ______________________________

Signs/Symptoms

□ Asymptomatic □ Fever □ Respiratory □ Bloody sputum

□ Cough □ Productive cough □ Rash □ Vomiting

□ Diarrhea □ Stool + Blood □ Stool + Mucous □ Abdominal Pain

□ Apnea □ SIDS □ Sudden Unexplained Death

□ Other____________________________________

Recent Exposure (if applicable) □ Birds □ Ticks □ Mosquitoes

□ Other ____________________________________

Date of Onset: ______/________/________ (mm dd yyyy)

Deceased Date: ______/________/_______ (mm dd yyyy)

Vaccine Administered______________________________
(Please specify)

Vaccine Administration Date______/_______/____________ (mm dd yyyy)

Antibiotics/Anti-Viral Used ________________________
(Please specify)

Antibiotics/Antiviral Start Date ______/_______/__________ (mm dd yyyy)

Special Information for Laboratorians

Outbreak Related □ no □ yes Outbreak Number: _____________________

Role of Patient (ex. food-handler, patron):______________________________

□ Other Information____

***Complete information on back**

COMMONWEALTH OF VIRGINIA – DEPARTMENT OF GENERAL SERVICES
DIVISION OF CONSOLIDATED LABORATORY SERVICES

Clinical Microbiology/Virology Request Form

Test Request: **Patient Name/Identifier**___________________________ **Date of Birth** ____ /___ /________

Enteric Screen/ Enteric Pathogens

Date Specimen Collected _____/_____/_______ (mm dd yyyy)

Stool preserved in Cary-Blair Transport (Ship Room Temp)
- □ Salmonella/Shigella/E. coli 0157/Campylobacter
- □ Shiga Toxin □ Yersinia □ Vibrio
- □ Other__________________________

Unpreserved Stool (Ship Cold Pack)
- □ Norovirus
- □ Other___________________________

Follow-up specimen? □ yes □ no If yes, what organism__________________________

Parasites: Intestinal and Blood-borne

Date(s) Collected (1) ___/______/______; (2) ___/______/______ (mm dd yyyy)

- □ Ova and Parasite □ Pinworm
- □ Cyclospora □ Blood Parasites
- □ Giardia/Cryptosporidium FA
- □ Other_________________

Submitted in: (Room Temp)
- □ 10% Formalin □ PVA □ EDTA Blood
- □ Smears/slides □ Other_________________

Unpreserved Stool (Cold Pack) Upon Request
- □ Cyclospora □ Other_________________
- □ Cryptosporidium

□ Refugee Country visited outside US____________________________

Pertussis

Date Specimen Collected ____/____/_____ (mm dd yyyy)

B. pertussis: □ Culture □ PCR B. parapertussis: □ Culture
□ Other____________________________________

Source:
- □ Nasopharyngeal Swabs (Right and Left Nares)
- □ Other____________________________________

Clinical / Specimen Culture (Including OCME): □ Bacterial □ Fungal □ Viral □ Toxin

Date Specimen Collected ____/_____/______ (mm dd yyyy)

Source: □ Blood □ Urine □ Sputum □ Stool □ Swab (site) ___________ □ Wound/Lesion (Site)__________ □ Respiratory ____________________________

□ Tissue (type) _________________ □ Body Fluid (type)____________________ □ Other ___________________________________

Organism/Toxin Suspected: _________________________________ **Submitted on** (type media) ___________________________________

Reference Culture / Isolate: □ Bacterial □ Enteric □ Fungal □ Viral □ PFGE

Date Specimen Collected ____/_____/_______ (mm dd yyyy)

Test Requested: ____

Source: □ Blood □ CSF □ Urine □ Sputum □ Stool □ Swab (site)___________ □ Wound/Lesion(Site)_________ □ Respiratory_________________________

□ Tissue (type) ____________________□ Body Fluid (type) ____________________ □ Other_____________________________________

Organism Suspected: ___________________________________ **Submitted on** (type of media) _______________________________________

Specimen or Reference Culture for TB or other AFB (*Mycobacterium* spp.)

Date Specimen Collected: (1) _____/_____/______ (2) _____/______/______ (3) _____/_____/_______ (mm dd yyyy)

Specimen Source: □ Spontaneous Sputum □ Induced Sputum □ Bronchial Wash/BAL □ Pleural Fluid □ CSF □ Peritoneal Fluid □ Lymph Node □ Blood □ Urine □ Stool □ Tissue (type) ____________________ □ Other___________________

Sputum Type: □ Raw □ Partially processed □ Processed □ Postmortem

Organism Suspected: ____**Submitted on** (type media) ____________________________________

Additional testing requested: □ 2nd line drugs ____

Information to be included on final report as per request of submitter: