

**Clinical Microbiology/Virology Request Form**

**Patient Information (Please Print)**

Name \_\_\_\_\_ DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_  M  F  
 Last First Middle Initial  
 mm dd yyyy  
 Pt Address \_\_\_\_\_ City \_\_\_\_\_, State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 City/County of Residence \_\_\_\_\_ Patient Phone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 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					
<input type="radio"/> STD	<input type="radio"/> ATS	<input type="radio"/> DCJ	<input type="radio"/> FP	<input type="radio"/> GYN	<input type="radio"/> Priv Phys
<input type="radio"/> OB/prenatal care	<input type="radio"/> AHC	<input type="radio"/> Field	<input type="radio"/> IMM	<input type="radio"/> Job Corp	<input type="radio"/> Peds
<input type="radio"/> TB	<input type="radio"/> GMC	<input type="radio"/> CHC	<input type="radio"/> DTC	<input type="radio"/> Refugee	<input type="radio"/> SOI
<input type="radio"/> Hospital	<input type="radio"/> OCME	<input type="radio"/> Student HC	<input type="radio"/> 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 \_\_\_\_\_

**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 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**Source:**

- Nasopharyngeal Swabs (Right and Left Nares)  
 Other \_\_\_\_\_

**B. pertussis:**  Culture  PCR    **B. parapertussis:**  Culture  
 Other \_\_\_\_\_

**Clinical / Specimen Culture (Including OCME):** Bacterial     Fungal     Viral     ToxinDate 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     PFGEDate 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 mm dd yyyy 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:**