

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 _____
 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"/> ATC	<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 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 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: