

Commonwealth of Virginia
 Department of General Services
 Division of Consolidated Laboratory Services
 Richmond, Virginia

DCLS Test Request Form

For assistance, please refer to *Instructions for Completing DCLS Test Request Form (Qualtrax ID # 34961)*

PATIENT INFORMATION		SUBMITTER INFORMATION	
Last Name:		Submitting Facility:	
First Name: M.I.		Address:	
Birth Date: / / <input type="checkbox"/> Male <input type="checkbox"/> Female		City:	
Address:		State:	Zip code:
City:	State:	Zip code:	Phone:
County:	MRN:	Attending Clinician:	
Patient ID:	External ID:	Attending Clinician Phone:	
Race:	Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino	Public Health Dept Contact:	
Phone:	Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No	Public Health Contact Phone:	
PATIENT MEDICAL HISTORY			
Disease Suspected or Diagnosis:			
Date of Onset: / /		Deceased Date: / /	
Signs/Symptoms: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Cough <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Headache <input type="checkbox"/> Malaise/Fatigue <input type="checkbox"/> Myalgia <input type="checkbox"/> Pneumonia <input type="checkbox"/> Rash <input type="checkbox"/> Vomiting <input type="checkbox"/> Other:			
Recent Exposure: <input type="checkbox"/> Sexual Contact <input type="checkbox"/> Birds <input type="checkbox"/> Ticks <input type="checkbox"/> Mosquitos <input type="checkbox"/> Other:			
Vaccine Administered:		Vaccine Administration Date: / /	
Antibiotics/Antiviral Used:		Antibiotics/Antiviral Start Date: / /	
Origin country (if not USA):			
Recent Countries visited outside USA:		Dates: / / to / /	
Recent States visited inside USA:		Dates: / / to / /	
OUTBREAK INFORMATION			
Outbreak Related? <input type="checkbox"/> Yes <input type="checkbox"/> No		VDH Designated Outbreak #:	
Role of Patient (ex. Food handler, daycare provider):			
SPECIMEN COLLECTION INFORMATION			
Date Collected: / /		Submitted On (ex. media type, collection container):	
Reason for Test Request: <input type="checkbox"/> Isolate for ID/Confirmation <input type="checkbox"/> VDH Reportable Disease Compliance <input type="checkbox"/> Surveillance <input type="checkbox"/> Diagnosis <input type="checkbox"/> Contact/Suspected Carrier <input type="checkbox"/> Clearance/Release <input type="checkbox"/> Send Out / Diagnosis <input type="checkbox"/> Other:			
Specimen Source: <input type="checkbox"/> Blood <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Buccal Swab <input type="checkbox"/> Sputum <input type="checkbox"/> Bronchial Wash <input type="checkbox"/> BAL <input type="checkbox"/> Nasopharyngeal Swab <input type="checkbox"/> Oropharyngeal/Throat Swab <input type="checkbox"/> Tissue - type: <input type="checkbox"/> Body Fluid - type: <input type="checkbox"/> Wound - site: <input type="checkbox"/> Other Swab - site: <input type="checkbox"/> Other:			
Organism Suspected:			
Follow-up specimen? <input type="checkbox"/> Yes <input type="checkbox"/> No		CIDT Specimen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
PulseNet referral? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date PulseNet specimen received: / /	
Submitter Test Method for ID/Detection:			
Submitter Test Method for AST (if applicable):			
Rapid Test(s) Used (if applicable):		Rapid Test Results:	
ADDITIONAL INFORMATION	*Place Medical Patient Label, if applicable*	*DCLS STATE LAB USE ONLY*	

Patient Name / Identifier _____

Date of Birth ____ / ____ / ____

TEST REQUEST (Place check in box next to desired test)			
Viral Testing			
<input type="checkbox"/> Influenza detection/subtyping <input type="checkbox"/> PCR <input type="checkbox"/> Viral Culture		WNV (West Nile Virus), EEE (Eastern Equine Encephalitis), SLE (Saint Louis Encephalitis, LAC (La Crosse Encephalitis)	
<input type="checkbox"/> Influenza A, un-subtypeable		Chikungunya <input type="checkbox"/> PCR <input type="checkbox"/> Serology	
<input type="checkbox"/> Novel Influenza		Dengue <input type="checkbox"/> PCR <input type="checkbox"/> Serology	
<input type="checkbox"/> Highly Pathogenic Avian Influenza (HPAI)		Zika <input type="checkbox"/> PCR <input type="checkbox"/> Serology	
<input type="checkbox"/> Measles (Rubeola) * <input type="checkbox"/> PCR <input type="checkbox"/> Viral Culture <input type="checkbox"/> Serology		Other Arbovirus:	
<input type="checkbox"/> Mumps * <input type="checkbox"/> PCR <input type="checkbox"/> Viral Culture <input type="checkbox"/> Serology		Ebola Virus *	
<input type="checkbox"/> Varicella Zoster Virus (VZV) * <input type="checkbox"/> PCR <input type="checkbox"/> Viral Culture		Coronavirus infection * Suspected Virus:	
<input type="checkbox"/> Smallpox (Variola virus) *†		Viral Culture for ID Suspected ID:	
<input type="checkbox"/> Smallpox Vaccine Adverse Event (Vaccinia virus) *			
Biothreat Rule Out / Confirmatory Testing		Bacteriology ID / Detection	
<input type="checkbox"/> Anthrax (<i>Bacillus anthracis</i>)†^		PulseNet Sample	Submitter Key ID #:
<input type="checkbox"/> Botulism (<i>Clostridium botulinum</i>) *†		Bacterial isolate for ID	Suspected ID:
<input type="checkbox"/> Brucellosis (<i>Brucella</i> species)† <input type="checkbox"/> PCR <input type="checkbox"/> Serology		Bacterial Meningitis (PCR)	
<input type="checkbox"/> <i>Burkholderia mallei</i> / <i>pseudomallei</i> †		Carbapenem Resistant Organism**	
<input type="checkbox"/> Plague (<i>Yersinia pestis</i>)†		Suspected ID:	
<input type="checkbox"/> Q fever (<i>Coxiella burnetii</i>)†		Diphtheria (<i>Corynebacterium diphtheriae</i>)	
<input type="checkbox"/> Tularemia (<i>Francisella tularensis</i>)†		<i>Haemophilus influenzae</i> infection, invasive	
Enteric Culture / ID / Detection††		Listeriosis (<i>Listeria monocytogenes</i>)	
<input type="checkbox"/> <i>Campylobacteriosis</i> (<i>Campylobacter</i> species)		Meningococcal disease (<i>Neisseria meningitidis</i>)	
<input type="checkbox"/> Enteric Screen Culture (VDH request only)		Pertussis / <i>Bordetella</i> species <input type="checkbox"/> Culture <input type="checkbox"/> PCR	
<input type="checkbox"/> Enterotoxigenic <i>B. cereus</i> (VDH request only)		Streptococcal disease, Group A (<i>S. pyogenes</i>), invasive	
<input type="checkbox"/> Enterotoxigenic <i>C. perfringens</i> (VDH request only)		Vancomycin-intermediate/resistant <i>S. aureus</i> (VISA/VRSA)**	
<input type="checkbox"/> Enterotoxigenic <i>S. aureus</i> (VDH request only)		<i>Vibrio</i> species	
<input type="checkbox"/> Norovirus (VDH request only)		Other:	
<input type="checkbox"/> Salmonellosis (<i>Salmonella</i> species)		Mycology	
<input type="checkbox"/> Shiga toxin-producing <i>Escherichia coli</i> infection (STEC)		Actinomycete for ID	Suspected ID:
<input type="checkbox"/> Shigellosis (<i>Shigella</i> species)		<i>Candida</i> species <input type="checkbox"/> <i>C. auris</i> <input type="checkbox"/> <i>C. haemulonii</i>	
<input type="checkbox"/> Vibriosis (<i>Vibrio</i> species) / Cholera (<i>Vibrio cholerae</i> O1/O139)		Mold for ID	Suspected ID:
<input type="checkbox"/> Yersiniosis (<i>Yersinia</i> species) (other than <i>pestis</i>)		Yeast isolate for ID	Suspected ID:
Send Out Testing^^		Mycobacteriology / AFB	
<input type="checkbox"/> Test Request:		<i>Mycobacterium tuberculosis</i> complex (compliance)	
		<i>M. tuberculosis</i> complex Genotyping (VDH request only)	
		Nontuberculous Mycobacteria ID (VDH request only)	
Miscellaneous			
Congenital Cytomegalovirus – Newborn Screening		Adult Sickle Cell	
Date of Failed Hearing Test: / /		Previous transfusion?	
External ID #:		Transfusion Date: / /	
Mother's Name:		Testing Reason: <input type="checkbox"/> Routine <input type="checkbox"/> Premarital <input type="checkbox"/> Prenatal	
Mother's Date of Birth: / /		<input type="checkbox"/> Family Planning <input type="checkbox"/> Family Study <input type="checkbox"/> Amnio Patient	
Pediatrician Name:		<input type="checkbox"/> Confirm known disease or trait <input type="checkbox"/> Other:	
Pediatrician Phone:		ABO Testing – Blood Group and Rh Type	
Pediatrician Address:		Was Rhogam given? <input type="checkbox"/> Yes <input type="checkbox"/> No	
City: State: Zip code:		If yes, Testing date: / /	
Malaria (EDTA Blood specimen only)		Was a previous antibody identified? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Rubella Immunity Screening		If so, what was the antibody?	
Other:			

* VDH approval is required prior to submission.

† Possible Select Agent – Notification and consultation with DCLS is required prior to submission.

** Submission must include a copy of laboratory susceptibility testing results.

†† Submission should include a copy of laboratory CIDT report for specimens, if applicable.

^ Routine rule out testing of *Bacillus* species does NOT require prior notification or consultation with DCLS.

^^ Specimens for Send Out Testing may require additional documentation. Please consult with DCLS prior to submission.