

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

Instructions for Completing DCLS Test Request Form

PURPOSE

To be used when requesting testing of biological and potentially pathogenic agents at the Division of Consolidated Laboratory Services.

FORM

This is an Instructional document for completion of the 2-page *DCLS Test Request Form* (Qualtrax ID # 16857). A Fillable PDF version is available online:

<https://dgs.virginia.gov/division-of-consolidated-laboratory-services/resources/submission-forms>

Patient Information

Complete the relevant fields for the Patient, including Medical Record Number (MRN#) and Patient ID, if available. If Race is applicable to testing, enter the appropriate abbreviation:

- 1) BLK- Black
- 2) WHT- Caucasian
- 3) ASIAN- Chinese, Filipino, Indian, Japanese, Korean, Pakistani, Thai, Vietnamese
- 4) AMER. INDIAN- American Indian, Alaskan Native
- 5) MIXED/OTHER– Biracial, Mixed, Unknown

PATIENT INFORMATION			
Last Name:			
First Name:			M.I.
Birth Date: / /		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Address:			
City:		State:	Zip code:
County:		MRN:	
Patient ID:		External ID:	
Race:		Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino	
Phone:			Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No

Submitter Information

Enter the name and contact information of the Healthcare Facility where the Patient is being treated. Provide Contact info, should a follow-up need to be obtained. Submitter has the option to enter the name and phone number of the Attending Clinician. If applicable, enter the name and phone number of the Public Health Contact.

SUBMITTER INFORMATION	
Submitting Facility:	
Address:	
City:	
State:	Zip code:
Phone:	Fax:
Attending Clinician:	
Attending Clinician Phone:	
Public Health Dept Contact:	
Public Health Contact Phone:	

Patient Medical History / Outbreak Information

Complete the fields for Patient Medical History, if applicable to Patient, additional instructions for select fields listed below:

***Note:** Travel history **required** for Test Requests of **"Influenza A"** and **"Novel Influenza"**.

- 1 SIGNS/SYMPTOMS** – Select checkboxes of all relevant signs/symptoms that the Patient has exhibited during ailment. If experiencing additional symptoms not listed, select the "Other" checkbox and enter symptoms in the space provided.
- 2 RECENT EXPOSURE** – Select checkboxes for any potential exposures. If an appropriate exposure is not listed, select "Other" checkbox and enter the suitable exposure.
- 3 VACCINE ADMINISTERED, DATE** – List all relevant vaccines to the Patient and date(s) administered.
- 4 ANTIBIOTICS / ANTIVIRAL USED, DATE** – List all relevant antibiotics/antivirals administered during course of Patient ailment, and Start Date.
- 5 ORIGIN COUNTRY** – If not from United States, list Patient's Country of Origin,
- 6 RECENT COUNTRIES / STATES VISITED... (with DATES: from/to)** – List all Countries recently visited outside USA, include date ranges of travel. List all U.S. States recently visited outside Virginia, include date ranges of travel.
- 7 OUTBREAK RELATED?** – If Patient Case is a suspected outbreak, select "YES" checkbox, and proceed to questions.

Document #:34961

Revision: 1

Date Published: 07/31/20

Issuing Authority: Group Manager

PATIENT MEDICAL HISTORY	
Disease Suspected or Diagnosis:	
Date of Onset: / /	Deceased Date: / /
1 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:	
2 Recent Exposure: <input type="checkbox"/> Sexual Contact <input type="checkbox"/> Birds <input type="checkbox"/> Ticks <input type="checkbox"/> Mosquitos <input type="checkbox"/> Other:	
3 Vaccine Administered:	Vaccine Administration Date: / /
4 Antibiotics/Antiviral Used:	Antibiotics/Antiviral Start Date: / /
5 Origin country (if not USA):	
6 Recent Countries visited outside USA:	Dates: / / to / /
Recent States visited inside USA:	Dates: / / to / /
OUTBREAK INFORMATION	
7 Outbreak Related? <input type="checkbox"/> Yes <input type="checkbox"/> No	VDH Designated Outbreak #:
Role of Patient (ex. Food handler, daycare provider):	

Specimen Collection Information

Complete the fields for Specimen Collection Information, if applicable, additional instructions for select fields listed below:

- 8 **SUBMITTED ON** – Provide the media type or container type that the Specimen was submitted on by the Submitter.
- 9 **REASON FOR TEST REQUEST** – Select the checkbox of the relevant reason(s) for the Test Request. If an appropriate reason is not found, select the “Other” checkbox and enter the suitable reason in the space.
- 10 **SPECIMEN SOURCE** – Select the checkbox of the relevant Specimen Source for the Test Request. If a Source is not listed, select the “Other” checkbox and enter a suitable Specimen Source in the space provided.
- 11 **CIDT SPECIMEN** – Select the checkbox if sample is a Culture-Independent Diagnostic Test, e.g., a direct specimen PCR test or enzyme immunoassay.
- 12 **PULSENET REFERRAL** – Mark the checkbox and date received if sample is a PulseNet referral for Whole Genome Sequencing.
- 13 **SUBMITTER TEST METHOD FOR ID/DETECTION / AST** – If Submitter has conducted initial testing for ID/Detection, or AST, provide test method performed.
- 14 **RAPID TEST(S) USED (IF APPLICABLE)** – Enter Rapid Diagnostic Tests used (e.g., Influenza, RSV, etc.), and results.

SPECIMEN COLLECTION INFORMATION	
Date Collected: / /	8 Submitted On (ex. media type, collection container):
9 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:	
10 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	11 CIDT Specimen? <input type="checkbox"/> Yes <input type="checkbox"/> No
12 PulseNet referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date PulseNet specimen received: / /
13 Submitter Test Method for ID/Detection:	
Submitter Test Method for AST (if applicable):	
14 Rapid Test(s) Used (if applicable):	Rapid Test Results:

Additional Information Section

ADDITIONAL INFORMATION – Provide any additional info that Submitter would like to include on the Final Report.

Test Request

Examine the Test Request List on Page 2 of the Submitter Form, and place a check next to the desired Test. Complete any additional Test Request information, including checkboxes for test type (PCR, Viral Culture, etc.), for “Testing Reason”, for sub-species, or a fill-in blank for “Testing Date”, etc. When completing the “Suspected...” fields, list the suspected pathogen in the space provided if possible. Example: “Coronavirus infection - Suspected Virus: **SARS-COV-2**”.

Example: To order a Yeast isolate for ID:

- 1.) Mark the checkbox to the left of desired Test.
- 2.) For Suspected ID: fill in blank with pathogen’s name or description e.g., *Cryptococcus neoformans*.

Mycology	
<input type="checkbox"/>	Actinomycete for ID Suspected ID:
<input type="checkbox"/>	<i>Candida</i> species <input type="checkbox"/> <i>C. auris</i> <input type="checkbox"/> <i>C. haemulonii</i>
<input type="checkbox"/>	Mold for ID Suspected ID:
<input checked="" type="checkbox"/>	Yeast isolate for ID Suspected ID: <i>Cryptococcus neoformans</i>