

**OFFICE OF LABORATORY SERVICES**

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PLACE BARCODE HERE

OLS USE ONLY

**MICROBIOLOGY LABORATORY SPECIMEN SUBMISSION FORM****PATIENT INFORMATION**

PATIENT ID (Chart #, etc.)		
LAST NAME	FIRST NAME	MI
DATE OF BIRTH	SS# (last 4 only, optional)	
COUNTY OF RESIDENCE	SEX <input type="checkbox"/> Female <input type="checkbox"/> Male	
STREET ADDRESS		
CITY	STATE	ZIP
PATIENT PHONE NO. (optional)		

**DATE OF COLLECTION:****SITE/SOURCE OF SPECIMEN:**

<input type="checkbox"/> Blood	<input type="checkbox"/> Sputum
<input type="checkbox"/> Cellulose tape mount	<input type="checkbox"/> Sputum, induced
<input type="checkbox"/> CSF	<input type="checkbox"/> Stool
<input type="checkbox"/> Nasopharyngeal	<input type="checkbox"/> Stool, bloody
<input type="checkbox"/> Rectal	<input type="checkbox"/> Throat
<input type="checkbox"/> Serum	<input type="checkbox"/> Urethra
<input type="checkbox"/> Serum, acute	<input type="checkbox"/> Urine
<input type="checkbox"/> Serum, convalescent	
<input type="checkbox"/> Wound ( <i>location:</i> )	
<input type="checkbox"/> Bronchial ( <i>specify:</i> )	
<input type="checkbox"/> Tissue ( <i>specify:</i> )	
<input type="checkbox"/> Fluid ( <i>specify:</i> )	
<input type="checkbox"/> Other ( <i>specify:</i> )	

**SUBMITTER INFORMATION**

FACILITY NAME		
MAILING ADDRESS		
CITY	STATE	ZIP
COUNTY		
ATTENTION TO:		
PHONE NO.		
FAX NO.		

**TEST(S) REQUESTED:**

BACTERIOLOGY	MYCOBACTERIOLOGY
<input type="checkbox"/> General/Referred Culture	<input type="checkbox"/> Culture/Smear <small>C</small>
<input type="checkbox"/> Pertussis culture	<input type="checkbox"/> TB ID/Confirmation <small>R</small>
<input type="checkbox"/> Enteric (stool in Cary-Blair)	<input type="checkbox"/> MOTT Identification <small>R</small>
<input type="checkbox"/> Gonorrhea culture	Suspected Organism:
<input type="checkbox"/> Gonorrhea smear	Date growth appeared:
<input type="checkbox"/> Unknown bacteriology ID	Patient taking TB drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No
Suspected Organism (s):	Skin Test <input type="checkbox"/> POS (+) <input type="checkbox"/> NEG (-)
	Chest X-ray <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
	Contact to TB patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Refrigerated? <input type="checkbox"/> Yes <input type="checkbox"/> No

**VIROLOGY ISOLATION**

<input type="checkbox"/> Respiratory Virus Panel
<input type="checkbox"/> Influenza A subtyping

**MOLECULAR**

<input type="checkbox"/> Norovirus RT-PCR
<b>ONLY AFTER IDEP CONSULTATION</b>
EPI CONTACT NAME:

COMMENTS:

**MANDATORY ARBOVIRUS INFORMATION**

Date of Symptom Onset:
Clinical Symptoms:
[CSF Information] Total WBC: Total Protein:

**MANDATORY VIROLOGY ISOLATION INFORMATION**

Travel History (Date/Location):	
Date of Symptom Onset:	
Animal Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	Avian Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No
Received current vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Vaccine Location: Within last 3 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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<input type="checkbox"/> SATISFACTORY	ACC:
<input type="checkbox"/> UNSAT   Reason/ID:	DE:
<input type="checkbox"/> UNRELIABLE   Reason/ID:	CKD:

**PARASITOLOGY**

<input type="checkbox"/> O&P, 10% formalin
<input type="checkbox"/> O&P, PVA
<input type="checkbox"/> O&P, other (inc. pinworm)