CLINICAL TEST REQUEST FORM

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

IBL USE ONLY
DO NOT MARK

SUBMITTING FACILITY

Facility: _____
Attention: _____
Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

SPECIMEN INFORMATION

Submitter Specimen ID:

Collection Date *(mm/dd/yy)*: **Time** *(hh:mm)*:

Type of Specimen: ☐ Isolate ☐ Original Material ☐ Other:

Original Material Type: ☐ Stool ☐ Serum ☐ Sputum ☐ Blood ☐ Swab ☐ Tissue ☐ CSF ☐ Aspirate ☐ Abscess/Lesion ☐ Wash ☐ Other:

Specimen Source Site *(arm, joint, urine, etc.)*: ☐ Bronchial ☐ Nasopharynx ☐ Pleural ☐ Other:

Suspected Organism:

Reason for Test: ☐ Diagnosis ☐ Surveillance ☐ Test of Cure

Part of an Outbreak? ☐ No ☐ Yes Outbreak #:

PATIENT INFORMATION

Patient Last Name:

Patient First Name & M.I.:

Medical Record # (MRN):

Date of Birth *(mm/dd/yyyy)*:

Sex: ☐ M ☐ F

Patient Residence (City, County, Zip):

Clinician Name *(if applicable)*:

Phone:

ANALYSIS REQUESTED

BACTERIOLOGY

Culture and ID
- ☐ Bacillus anthracis rule out
- ☐ Bacterial identification
- ☐ Bordetella pertussis (PCR only)
- ☐ Brucella rule out
- ☐ Burkholderia mallei/pseudomallei rule out
- ☐ Campylobacter spp.
- ☐ Francisella tularensis rule out
- ☐ Listeria
- ☐ Salmonella spp.
- ☐ Shiga toxin-producing E.coli
- ☐ Shigella spp.
- ☐ Vibrio spp.
- ☐ Yersinia spp.
- ☐ Yersinia pestis rule out

Antimicrobial Susceptibility
- ☐ Antimicrobial Susceptibility Confirmation
- ☐ Carbapenem Resistance Testing

BACTERIOLOGY (cont.)

Serotyping
- ☐ Haemophilus influenzae
- ☐ Neisseria meningitidis
- ☐ Salmonella Typhi

MYCOBACTERIOLOGY

- ☐ **New TB Suspect:** AFB Smear, TB NAAT, Culture, and Identification *(high risk of TB infection, or close contact of confirmed case)*
- ☐ **AFB Routine Workup:** AFB Smear, Culture, and Identification *(low risk of TB infection or a known active TB case)*
- ☐ **Mycobacterium spp. confirmation** (isolates only)

SEROLOGY

- ☐ HIV Ag/Ab Combo with Reflex*
- ☐ Syphilis testing (VDRL & TPPA)
- ☐ Hantavirus IgG/IgM*
- ☐ West Nile Virus IgM by EIA*

VIROLOGY

Viral Culture
- ☐ Upper Respiratory Virus Panel *Influenza A&B; Parainfluenza 1,2,3; Adenovirus; Respiratory Syncytial Virus*

PCR
- ☐ Measles virus*
- ☐ Mumps virus*
- ☐ Orthopox virus rule out
- ☐ Influenza A, B, and SARS-CoV-2 Multiplex*
  - ☐ Diagnostic ☐ Surveillance *(results not reported)*

SURVEILLANCE *(results are not reported for these tests)*

- ☐ Group A Strep subtyping
- ☐ SARS-CoV-2 Sequencing*
- ☐ Norovirus*
- ☐ Cryptosporidium & Giardia ID

OTHER TESTING *(Prior notification required)*

☐ _____
_____
_____

*SURVEILLANCE DATA

Please note: For items marked with an asterisk (*), complete the section below with as much information as possible.

Relevant Laboratory Tests *(attach copy of results if available)*:

Relevant Immunizations *(e.g., Influenza)*:

Type: ☐ Injection ☐ Intranasal Date *(mm/dd/yy)* :

Relevant Treatments *(i.e., antivirals, antibiotics, etc.)*

Date *(mm/dd/yy)*:

Symptomatic? ☐ Yes ☐ No ☐ Unknown If yes: record onset date of symptoms (if known): *(mm/dd/yy)*:

Has patient traveled in the last month? ☐ Yes ☐ No ☐ Unknown If yes: Destination(s):

Dates of travel: From: to

Mode of transportation:

SUBMITTER SPECIMEN LABEL *(optional)*

NOTES *(For IBL use only)*

Temperature: _____
Container Type: _____
Follow Up *(mm/dd/yy)*: _____ Initials: _____
Review *(mm/dd/yy)*: _____ Initials: _____

Idaho Bureau of Laboratories • 2220 Old Penitentiary Road • Boise, ID 83712
Visit StateLab.idaho.gov for IBL Sampling and Submission Guide.
Ph: (208) 334-2235
Fax: (208) 334-4083

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ADDITIONAL SUBMITTER COMMENTS

SUBMISSION INSTRUCTIONS

Please attach the completed form to specimen containers. For detailed guidelines on sampling and submission, visit StateLab.idaho.gov.

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