

CLINICAL TEST REQUEST FORM

IBL USE ONLY DO NOT MARK	SUBMITTING FACILITY Facility: _____ Attention: _____ Address: _____ City/State/Zip: _____ Phone: _____ Fax: _____
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SPECIMEN INFORMATION		
Submitter Specimen ID: _____	Collection Date (mm/dd/yy): _____	Time (hh:mm): _____
Type of Specimen: <input type="checkbox"/> Isolate <input type="checkbox"/> Original Material <input type="checkbox"/> Other:		
Original Material Type: <input type="checkbox"/> Stool <input type="checkbox"/> Serum <input type="checkbox"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> Swab <input type="checkbox"/> Tissue <input type="checkbox"/> CSF <input type="checkbox"/> Aspirate <input type="checkbox"/> Abscess/Lesion <input type="checkbox"/> Wash <input type="checkbox"/> Other:		
Specimen Source Site (arm, joint, urine, etc.): <input type="checkbox"/> Bronchial <input type="checkbox"/> Nasopharynx <input type="checkbox"/> Pleural <input type="checkbox"/> Other:		
Suspected Organism: _____	Reason for Test: <input type="checkbox"/> Diagnosis <input type="checkbox"/> Surveillance <input type="checkbox"/> Test of Cure	
	Part of an Outbreak? <input type="checkbox"/> No <input type="checkbox"/> Yes Outbreak #: _____	

PATIENT INFORMATION		
Patient Last Name: _____	Patient First Name & M.I.: _____	
Medical Record # (MRN): _____	Date of Birth (mm/dd/yyyy): _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Patient Residence (City, County, Zip): _____		
Clinician Name (if applicable): _____		Phone: _____

ANALYSIS REQUESTED		
BACTERIOLOGY Culture and ID <input type="checkbox"/> Bacillus anthracis rule out <input type="checkbox"/> Bacterial identification <input type="checkbox"/> Bordetella pertussis (PCR only) <input type="checkbox"/> Brucella rule out <input type="checkbox"/> Burkholderia mallei/pseudomallei rule out <input type="checkbox"/> Campylobacter spp. <input type="checkbox"/> Francisella tularensis rule out <input type="checkbox"/> Listeria <input type="checkbox"/> Salmonella spp. <input type="checkbox"/> Shiga toxin-producing E.coli <input type="checkbox"/> Shigella spp. <input type="checkbox"/> Vibrio spp. <input type="checkbox"/> Yersinia spp. <input type="checkbox"/> Yersinia pestis rule out Antimicrobial Susceptibility <input type="checkbox"/> Antimicrobial Susceptibility Confirmation <input type="checkbox"/> Carbapenem Resistance Testing	BACTERIOLOGY (cont.) Serotyping <input type="checkbox"/> Haemophilus influenzae <input type="checkbox"/> Neisseria meningitidis <input type="checkbox"/> Salmonella Typhi MYCOBACTERIOLOGY <input type="checkbox"/> New TB Suspect: AFB Smear, TB NAAT, Culture, and Identification (high risk of TB infection, or close contact of confirmed case) <input type="checkbox"/> AFB Routine Workup: AFB Smear, Culture, and Identification (low risk of TB infection or a known active TB case) <input type="checkbox"/> Mycobacterium spp. confirmation (isolates only) SEROLOGY <input type="checkbox"/> HIV Ag/Ab Combo with Reflex* <input type="checkbox"/> Syphilis testing (VDRL & TPPA) <input type="checkbox"/> Hantavirus IgG/IgM* <input type="checkbox"/> West Nile Virus IgM by EIA* OTHER TESTING (Prior notification required) <input type="checkbox"/> _____ _____ _____	VIROLOGY Viral Culture <input type="checkbox"/> Upper Respiratory Virus Panel <i>Influenza A&B; Parainfluenza 1,2,3; Adenovirus; Respiratory Syncytial Virus</i> PCR <input type="checkbox"/> Measles virus* <input type="checkbox"/> Mumps virus* <input type="checkbox"/> Hepatitis C virus (quantitative) <input type="checkbox"/> Orthopox virus rule out <input type="checkbox"/> Influenza A, B, and SARS-CoV-2 Multiplex* <input type="checkbox"/> Diagnostic <input type="checkbox"/> Surveillance (results not reported) SURVEILLANCE (results are not reported for these tests) <input type="checkbox"/> Group A Strep subtyping <input type="checkbox"/> SARS-CoV-2 Sequencing* <input type="checkbox"/> Norovirus*

*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: <input type="checkbox"/> Injection <input type="checkbox"/> Intranasal Date (mm/dd/yy) : _____	
Relevant Treatments (i.e., antivirals, antibiotics, etc.) _____	Date (mm/dd/yy): _____	
Symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes: record onset date of symptoms (if known): (mm/dd/yy): _____		
Has patient traveled in the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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: _____

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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.