CLINICAL TEST REQUEST FORM

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

LAB USE ONLY
DO NOT MARK

SUBMITTING FACILITY

Facility: _____

Attention: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

SPECIMEN INFORMATION

Specimen Collection Date *(mm/dd/yy)*:

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

Specimen Collection Site:

Specimen Type: ☐ Isolate: *Source of Isolate*: _____ ☐ Blood ☐ CSF ☐ Urine ☐ Stool ☐ Serum ☐ NP Aspirate

☐ Sputum ☐ Buccal Swab ☐ Nasal Swab ☐ NP Swab ☐ Throat Swab ☐ Other: _____

PATIENT INFORMATION

Patient Last Name:

Patient First Name:

Medical Record # (MRN):

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

Sex: ☐ M ☐ F

Patient Residence (City, County, Zip):

Onset Date *(mm/dd/yy)*:

BACTERIOLOGY

Culture and ID

- ☐ Bacillus anthracis rule out
- ☐ Bacterial identification
- ☐ Bordetella pertussis (PCR only)
- ☐ Brucella rule out
- ☐ Burkholderia mallei/pseudomallei rule out
- ☐ Campylobacter spp.
- ☐ Coxiella burnetii rule out (PCR only)
- ☐ 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
- ☐ Carbapenemase Resistance Testing

Serotyping

- ☐ Haemophilus influenzae
- ☐ Neisseria meningitidis

MYCOBACTERIOLOGY

- ☐ Routine Workup
- ☐ New Suspect
- ☐ Known Active Case
- ☐ AFB Smear and Culture
- ☐ AFB Identification
- ☐ AFB Culture Only
- ☐ TB NAAT

SEROLOGY

- ☐ HIV Antibody Screen
- ☐ HIV Rapid Test Confirmation
  HIV Rapid Test Result: ☐ Positive ☐ Negative
- ☐ Syphilis testing: ☐ *Routine or* ☐ *Symptomatic*
  - ☐ VDRL
  - ☐ TPPA
- ☐ Hantavirus IgG/IgM
- ☐ West Nile Virus IgM by EIA (serum)
  *Onset date required (mm/dd/yy):*_____

VIROLOGY

Viral Culture

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

PCR

- ☐ Measles virus
- ☐ Mumps virus
- ☐ Hepatitis C virus (quantitative)
- ☐ Orthopox virus rule out
- ☐ Influenza A, B, and SARS-CoV-2 Multiplex
  **See Influenza Surveillance Data Below*

SURVEILLANCE

- ☐ Group A Strep subtyping
- ☐ SARS-CoV-2 Sequencing
- ☐ Norovirus

OTHER TESTING *(Prior notification required)*

☐ _____

_____

_____

INFLUENZA SURVEILLANCE DATA*

Yes	No	Unknown	
☐	☐	☐	Was patient vaccinated against influenza? If yes: ☐ Injection ☐ Intranasal Date *(mm/dd/yy)*: _____
☐	☐	☐	Has patient recently been tested for influenza? If yes: Results: ☐ A ☐ B ☐ Negative Date *(mm/dd/yy)*: _____
☐	☐	☐	Does patient have Influenza-like illness? If yes: Date of symptom onset *(mm/dd/yy)*: _____
☐	☐	☐	Has patient traveled in the last month? If yes: Destination: _____ Mode of transportation: _____
☐	☐	☐	Did patient receive antiviral treatment within the past month?

SEND REPORT COPY

Facility: _____

Attention: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

NOTES *(For lab 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 Sampling and Submission Guides and Client Billing Form.
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.
For use with TB testing, fold this form in fourths (fold in half twice), wrap around inner container, and insert into tube.

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