



LABORATORY USE ONLY

*CLIENT NUMBER	*PATIENT NAME/ADDRESS (please print last, first)		
*CLIENT INFORMATION	LAST	FIRST	M.I.
NAME	STREET		
STREET ADDRESS	APT #		
CITY	STATE	ZIP	
PHYSICIAN INFORMATION (if different from above)			
NAME/CLINIC CODE	PHONE #		
STREET ADDRESS	CITY		
CITY	STATE	ZIP	
PATIENT NUMBER/CODE			
*BIRTHDATE		*AGE	*SEX
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>M M D D Y Y</small>		<input type="text"/> <input type="text"/> <small>Hour Minute</small>	<input type="checkbox"/> M <input type="checkbox"/> F
*DATE SPECIMEN TAKEN			*TIME TAKEN
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>M M D D Y Y</small>			<input type="text"/> <input type="text"/> <input type="text"/> <small>Hour Minute (circle one)</small>
Diagnosis/Symptoms _____ Release () Case () Contact () Carrier ()			

CHECK DESIRED SPECIMEN SOURCE

CULTURE REQUEST	IMMUNOLOGY REQUEST
*SPECIMEN SOURCE: (Check only one) <input type="checkbox"/> 1 throat <input type="checkbox"/> 5p processed sputum <input type="checkbox"/> 470 penis <input type="checkbox"/> 2 stool <input type="checkbox"/> 6 gastric <input type="checkbox"/> 11 superficial wound <input type="checkbox"/> 479 urethra <input type="checkbox"/> 3 eye <input type="checkbox"/> 7 aerosol <input type="checkbox"/> 12 deep wound <input type="checkbox"/> 531 vagina <input type="checkbox"/> 4 blood <input type="checkbox"/> 8 urine <input type="checkbox"/> 16 rectal swab <input type="checkbox"/> tissue _____ (Specify) <input type="checkbox"/> 5 sputum <input type="checkbox"/> 9 ear <input type="checkbox"/> 17 CSF <input type="checkbox"/> 1803 pinworm paddle <input type="checkbox"/> 95 cervix <input type="checkbox"/> 13 other _____ (Specify source)	SPECIMEN SOURCE: (Check only one) <input type="checkbox"/> 1 blood/serum <input type="checkbox"/> 5 oral fluid <input type="checkbox"/> 3 other _____ <input type="checkbox"/> 2 CSF <input type="checkbox"/> 9 blood/plasma <input type="checkbox"/> _____ (Specify) SPECIMEN TYPE: (Check only one) <input type="checkbox"/> 1 acute <input type="checkbox"/> 2 convalescent <input type="checkbox"/> Onset date: _____

CHECK DESIRED TEST

VENEREAL DISEASE	VIROLOGY
<input type="checkbox"/> GC1 Gonorrhea Culture <input type="checkbox"/> MI16 GC microscopic exam <input type="checkbox"/> VC75 Chlamydia/Gonorrhea Nucleic Acid Amplification <input type="checkbox"/> BC6 <i>G. vaginalis</i> Culture <input type="checkbox"/> BC7 <i>H. ducreyi</i> Culture <input type="checkbox"/> BC8 <i>Ureaplasma/Mycoplasma</i> Culture <input type="checkbox"/> MI13 Trichomonas microscopic exam <input type="checkbox"/> MI14 Yeast microscopic exam <input type="checkbox"/> MI15 Syphilis darkfield microscopic exam	<input type="checkbox"/> VI24 Viral Culture, Herpes Screen <input type="checkbox"/> VI32 Viral ID, Rabies <input type="checkbox"/> VI22 Viral culture _____ (Specify)
MISCELLANEOUS	PARASITOLOGY
<input type="checkbox"/> MI11 Urinalysis <input type="checkbox"/> MI12 Pregnancy <input type="checkbox"/> MI17 Occult blood	<input type="checkbox"/> PA27 Ova & Parasite Exam <input type="checkbox"/> PA26 Pinworm Exam <input type="checkbox"/> PA27A <i>Cryptosporidium</i> <input type="checkbox"/> PA27B <i>Microsporidium</i> <input type="checkbox"/> PA27C <i>Pneumocystis</i> <input type="checkbox"/> PA27D <i>Isospora</i> <input type="checkbox"/> PA27E <i>Cyclospora</i> <input type="checkbox"/> PA27F <i>Paragonimus</i> <input type="checkbox"/> PA27G <i>Giardia lamblia</i> screen <input type="checkbox"/> PA27H <i>E. histolytica</i> <input type="checkbox"/> PA28 Malaria/Blood parasite <input type="checkbox"/> PA29 Arthropods <input type="checkbox"/> PA30 Helminth Identification
ENTERICS	MYCOLOGY
<input type="checkbox"/> BE2 <i>Salmonella/Shigella</i> Culture <input type="checkbox"/> BE3 <i>Campylobacter</i> Culture <input type="checkbox"/> BE4D <i>E. coli</i> O157-H7 Culture	<input type="checkbox"/> FC20 Mycology Primary specimen (Fungus/yeast)
CLINICAL	MYCOBACTERIA
<input type="checkbox"/> BC5 Streptococcus Group A Culture (throat screen) <input type="checkbox"/> BC9A Bacterial Culture & Sensitivity, Aerobic <input type="checkbox"/> BC9B Bacterial Culture, Anaerobic (must contact lab)	<input type="checkbox"/> TB18 Mycobacterium Culture & Sensitivity (D1, D2, D3, D4, F, O) <input type="checkbox"/> TB18NA1 M. tuberculosis Complex (NAAT) Nucleic Acid Amplification Test <input type="checkbox"/> TB18NJ Antimicrobial Drug Levels (Call lab)
OTHER CULTURE	
<input type="checkbox"/> OC _____ (Specify)	

CHECK DESIRED TEST

SYPHILIS	HIV
<input type="checkbox"/> SS1 Syphilis Screen (RPR/VDRL) <input type="checkbox"/> SS2 Syphilis Confirmation	<input type="checkbox"/> VH31 HIV Antibody <input type="checkbox"/> VH74 HIV Antibody, Oral Fluid <input type="checkbox"/> VH72 HIV Viral Load (Time collected _____) <input type="checkbox"/> VH72AHIV Viral Load Ultra Sensitive (Time collected _____)
HEPATITIS	VIRAL
<input type="checkbox"/> Hepatitis Screen Acute: VS26 Hepatitis A IgM VS67 Hepatitis B Surface Antigen VS62 Hepatitis B Core IgM <input type="checkbox"/> Hepatitis B Carrier Screen: VS27 Hepatitis B Surface antigen <input type="checkbox"/> Hepatitis B Immunity, vaccinated VS28 Anti-HBSAg <input type="checkbox"/> Hepatitis B Immunity, past case VS29 Hepatitis B Core antibody <input type="checkbox"/> Hepatitis C VS66 Hepatitis C Antibody Total	Rash: Measles (Rubeola) Antibody: <input type="checkbox"/> VS17 IgG (Immune Status) <input type="checkbox"/> VS17 IgM (active case) Rubella Antibody <input type="checkbox"/> VS24 IgG (Immune Status) <input type="checkbox"/> VS63 IgM (active case)
	MISCELLANEOUS
	<input type="checkbox"/> VS9 Toxoplasma antibody <input type="checkbox"/> VS _____ Other (Specify)
	OTHER IMMUNOLOGY
	<input type="checkbox"/> OI _____ (Specify)

***REFERENCE CULTURE* Reference cultures must be pure and have all the * information completed.**

<input type="checkbox"/> GCID Gonorrhea Culture for Identification <input type="checkbox"/> SB10A Bacterial Culture for Identification Aerobic <input type="checkbox"/> SB10B Bacterial Culture for Identification, Anaerobic <input type="checkbox"/> BE2A Bacterial Culture for Identification, <i>Salmonella/Shigella</i> <input type="checkbox"/> FC21 Mycology Reference Culture for Identification <input type="checkbox"/> TB19 Mycobacterium Reference Culture for Identification <input type="checkbox"/> TB19RD <i>M. tuberculosis</i> Culture for Reportable Diseases only <input type="checkbox"/> TB19A <i>M. tuberculosis</i> Reference Culture Identification & Susceptibility <input type="checkbox"/> VI22A Viral Culture Identification	*CULTURE REFERRED AS: _____ *BRIEF BUT COMPLETE HISTORY, therapy, outcome: _____ *LABORATORY FINDINGS: _____
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