

## Vermont Department of Health Laboratory - Clinical Test Request Form

195 Colchester Avenue, PO Box 1125, Burlington, VT 05402-1125 • (802) 863-7336 / (800) 660-9997 in VT only

**A separate form is required for each specimen. All specimens must be labeled with patient name and date of collection.**

Specimen Information	For Laboratory Use Only
<b>Date of Collection:</b> _____ <b>Date of Onset:</b> _____ <b>Time of Collection:</b> _____ <b>ICD-9 Code:</b> _____	<b>Lab/LIMS #</b> _____ <b>Date Received:</b> _____ <b>LITS#:</b> _____

Clinical Laboratory/Practice Information	Patient Information
<b>Clinical Laboratory / Practice Name</b>	<b>Patient Last Name</b> _____ <b>Patient First Name</b> _____
<b>Address</b>	<b>Address</b>
<b>City/Town</b> _____ <b>State</b> _____ <b>Zip Code</b> _____	<b>City/Town</b> _____ <b>State</b> _____ <b>Zip Code</b> _____
<b>Telephone Number</b> _____ <b>Fax Number</b> _____	<b>Patient MRN# or ID#</b> _____ <b>Specimen ID#</b> _____
<b>Referring Physician Last Name/First Name</b>	<b>Birth Date (MM/DD/YYYY)</b> _____ <b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>NPI #</b>	<b>Travel History (within past 6 months)</b> _____ <b>Date Vaccinated for Influenza</b> _____
<b>Comments</b>	<b>TST History (For QFT Test Only)</b> Date: _____ Result mm: _____ <b>BCG Vaccinated (For QFT Test Only)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

<input type="checkbox"/> Check If No Insurance	Billing Information
<b>Responsible Party Name</b>	<b>Medicaid Number/Medicare Number</b> _____ <b>Phone Number</b> _____
<b>Insurance Company Name</b>	<b>Certificate Number</b> _____ <b>Group Number</b> _____
<b>Subscriber Name</b>	<b>Relationship</b>
<b>Secondary Insurance Company Name</b>	<b>Certificate Number</b> _____ <b>Group Number</b> _____
<b>Subscriber Name</b>	<b>Relationship</b>

Specimen Type
<input type="checkbox"/> Aspirate site: _____ <input type="checkbox"/> Biopsy Tissue <input type="checkbox"/> Blood <input type="checkbox"/> Capillary <input type="checkbox"/> Venous <input type="checkbox"/> Bone <input type="checkbox"/> Bronchial Wash <input type="checkbox"/> Bronchoalveolar Brush <input type="checkbox"/> Bronchoalveolar Lavage <input type="checkbox"/> CSF <input type="checkbox"/> Fluid - site: _____ <input type="checkbox"/> Isolate - source: _____ <input type="checkbox"/> Lymph Node <input type="checkbox"/> Nasal Swab <input type="checkbox"/> Nasopharyngeal Swab <input type="checkbox"/> Nasal Wash <input type="checkbox"/> Oral Mucosal Transudate (Oral Fluid) <input type="checkbox"/> Serum <input type="checkbox"/> Acute <input type="checkbox"/> Convalescent <input type="checkbox"/> Sputum <input type="checkbox"/> Stool <input type="checkbox"/> Swab <input type="checkbox"/> Urine <input type="checkbox"/> Other: _____

Specimen Site	Reason for Test
<input type="checkbox"/> Cervix <input type="checkbox"/> Endocervical <input type="checkbox"/> Lung <input type="checkbox"/> Nares <input type="checkbox"/> Nasal Mucosa <input type="checkbox"/> Nasopharynx <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Throat <input type="checkbox"/> Urethra <input type="checkbox"/> Other: _____	<input type="checkbox"/> Screen <input type="checkbox"/> Diagnostic <input type="checkbox"/> Confirmation/Reference <input type="checkbox"/> Contact/Exposure <input type="checkbox"/> Hospitalized <input type="checkbox"/> Immune Status <input type="checkbox"/> Immigrant/Refugee <input type="checkbox"/> Pregnancy <input type="checkbox"/> Per VDHL Request <input type="checkbox"/> Other: _____

## Laboratory Examination Requested

Bacteriology	Bacterial Typing/Fingerprinting	Serology (Misc.)
<input type="checkbox"/> Enteric Screen (Salmonella, Shigella, E. coli Shiga-like Toxin, Campylobacter, Yersinia) <input type="checkbox"/> E. coli Shiga-like Toxin <input type="checkbox"/> Gonnorrhea Culture <input type="checkbox"/> Gonorrhea/Chlamydia trachomatis Amplified <input type="checkbox"/> Legionella pneumophila Culture <input type="checkbox"/> Legionella pneumophila Antigen (urine) <input type="checkbox"/> Pertussis Culture <input type="checkbox"/> Pertussis Culture/PCR <input type="checkbox"/> Vibrio Culture <input type="checkbox"/> Isolate for Identification Organism suspected: _____ <input type="checkbox"/> Other:	<input type="checkbox"/> Campylobacter sp. <input type="checkbox"/> E. coli O157:H7 <input type="checkbox"/> Shiga Toxin Positive E. coli (STEC) <input type="checkbox"/> Haemophilus influenzae <input type="checkbox"/> Listeria sp. <input type="checkbox"/> Neisseria meningitidis <input type="checkbox"/> Salmonella sp. <input type="checkbox"/> Shigella sp. <input type="checkbox"/> Other:	<input type="checkbox"/> Brucella Total Antibody <input type="checkbox"/> Legionella pneumophila IgG <input type="checkbox"/> Mumps IgG <input type="checkbox"/> Rubella IgG <input type="checkbox"/> Rubeola IgG <input type="checkbox"/> Varicella zoster IgG <input type="checkbox"/> Rubella IgM (Diagnostic) <input type="checkbox"/> Rubeola IgM (Diagnostic) <input type="checkbox"/> Tularemia Total Antibody <input type="checkbox"/> Quantiferon-TB Gold In Tube test (QFT)* <input type="checkbox"/> Other:
	Mycobacteriology	Syphilis Serology
	<input type="checkbox"/> Mycobacterial Culture/Smear <input type="checkbox"/> Mycobacterial/Fungal Culture <input type="checkbox"/> Amplified M. tuberculosis Direct Test <input type="checkbox"/> Isolate for Identification <input type="checkbox"/> Isolate for Genotyping	<input type="checkbox"/> RPR Screen <input type="checkbox"/> FTA-ABS Confirmation <input type="checkbox"/> VDRL-Cerebral Spinal Fluid Only
Parasitology	Hepatitis Serology	HIV Serology
<input type="checkbox"/> Cryptosporidium EIA <input type="checkbox"/> Giardia EIA <input type="checkbox"/> Ova and Parasites (O & P) <input type="checkbox"/> Cyclospora <input type="checkbox"/> Pinworm <input type="checkbox"/> Worm for Identification <input type="checkbox"/> Other:	<input type="checkbox"/> Hepatitis B Panel (Surface Antigen, Surface Antibody, Core Total Antibody) <input type="checkbox"/> Hepatitis B Surface Antigen <input type="checkbox"/> Hepatitis B Core Total Antibody <input type="checkbox"/> Hepatitis B Surface Antibody <input type="checkbox"/> Hepatitis B Surface Antibody (for Vaccine Response) <input type="checkbox"/> Hepatitis C Antibody Screen	<input type="checkbox"/> HIV-1/HIV-2 Antibody EIA (serum) <input type="checkbox"/> HIV-1 Western Blot (confirmation only) <input type="checkbox"/> HIV-1 Oral Fluid
Virology		Toxicology
<input type="checkbox"/> Influenza A & B PCR		<input type="checkbox"/> Blood Lead - Pediatric <input type="checkbox"/> Blood Lead - Adult <input type="checkbox"/> Other:

\*The patient **MUST** have at least one of the risk factors listed below **BEFORE** testing will be performed at the VDHL. Please check all that apply.

- Contact with a person known or suspected to have TB (*M. tuberculosis*)
- Persons who have received the BCG (Bacille Calmette-Guerin) vaccine
- Foreign born person from areas with a high prevalence of TB
- Frequent or prolonged visits to areas with a high prevalence of TB
- A person at risk for TB/LTBI (Latent *M. tuberculosis* infection) who is unlikely to return to have a TST (Tuberculin Skin Test) read

**Incubation of QFT Tubes:**  QFT tubes incubated at 37°C       QFT tubes **NOT** incubated at 37°C

For Laboratory Use Only			
<input type="checkbox"/> Transport medium expired	<input type="checkbox"/> Duplicate of # _____	<input type="checkbox"/> QNS /Leaked in transit	<input type="checkbox"/> Overfilled
<input type="checkbox"/> Too old to test	<input type="checkbox"/> Other: _____		
Epidemiology notified of receipt of isolate: _____			
Epidemiology notified of preliminary results: _____		Epidemiology notified of final results: _____	
Provider notified of preliminary results: _____		Provider notified of final results: _____	

A copy of this form can be found at <http://www.healthvermont.gov/forms/forms.aspx> under Public Health Laboratory.