

Vermont Department of Health Laboratory – Clinical Test Request Form

195 Colchester Avenue, PO Box 1125, Burlington, VT 05402-1125 • (802) 863-7335 / (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.

| Clinic/Laboratory/Practice Information | | | | | | | | | | | |
|--|--|--|--|--|--|------------|--|-------|--|----------|--|
| CLINIC/LABORATORY/PRACTICE | | | | | | | | | | | |
| ADDRESS | | | | | | | | | | | |
| CITY/TOWN | | | | | | | | STATE | | ZIP CODE | |
| TELEPHONE NUMBER | | | | | | NPI # | | | | | |
| REFERRING PHYSICIAN LAST NAME | | | | | | FIRST NAME | | | | | |

| Specimen/Sample Information | |
|-------------------------------|---|
| ICD-9 Code: _____ | Date of Collection ___ / ___ / ___ |
| Date of Onset ___ / ___ / ___ | Date Vaccinated for Flu ___ / ___ / ___ |

| REASON FOR TEST | |
|---|---|
| <input type="checkbox"/> Screen | <input type="checkbox"/> Outbreak (Name _____) |
| <input type="checkbox"/> Confirmation/Reference | <input type="checkbox"/> Premarital (State) _____ |
| <input type="checkbox"/> Contact/Exposure | <input type="checkbox"/> Pregnancy/Prenatal |
| <input type="checkbox"/> Daycare Provider | <input type="checkbox"/> Symptomatic |
| <input type="checkbox"/> Diagnostic | <input type="checkbox"/> Test of Cure |
| <input type="checkbox"/> Food Handler | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Immune Status | <input type="checkbox"/> Foreign Travel History <small>(previous 6 months)</small> |
| <input type="checkbox"/> Immigrant/Refugee | |

| SPECIMEN | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Blood | <input type="checkbox"/> Induced Sputum | <input type="checkbox"/> Oral Mucosal |
| <input type="checkbox"/> Capillary <input type="checkbox"/> Venous | <input type="checkbox"/> Sputum | <input type="checkbox"/> Transudate |
| <input type="checkbox"/> Bronchial Washing | <input type="checkbox"/> Stool | <input type="checkbox"/> Swab |
| <input type="checkbox"/> Cerebral Spinal Fluid (CSF) | <input type="checkbox"/> Urine | <input type="checkbox"/> Aspirate |
| <input type="checkbox"/> Serum | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Acute <input type="checkbox"/> Convalescent | | |

| BACTERIAL TESTS | PARASITOLOGY TESTS | OTHER |
|---|--|---|
| Enteric Screen (<i>Salmonella</i> , <i>Shigella</i> , <i>E. coli</i> 0157, <i>Campylobacter</i> , <i>Yersinia enterocolitica</i>) | Cryptosporidium EIA | Legionella Urinary Antigen |
| E. coli Shiga-like Toxin Test | Giardia EIA | HEPATITIS SEROLOGY TESTS |
| Gonorrhea Culture | Ova & Parasites (O&P) | Hepatitis B Panel (<i>Surface Antigen</i> , <i>Surface Antibody</i> , <i>Core Total Antibody</i>) |
| Gonorrhea/Chlamydia trachomatis - Amplified | Cyclospora | Hep B Surface Antigen |
| Legionella Culture | Pinworm | Hep B Core Total Antibody |
| Pertussis Culture | Other: | Hep B Core IgM |
| Pertussis PCR/Culture | SEROLOGY TESTS (MISC.) | Hep B Surface Antibody |
| Vibrio Culture | Brucella Total Antibody | Hep B Surface Antibody (for Vaccine Response) |
| Other: | Legionella pneumophila IgG | Hepatitis C Antibody Screen |
| Isolate for Identification | Mumps IgG | SYPHILIS SEROLOGY TESTS |
| Organism suspected: | Rubella IgG | RPR Screen |
| BACTERIAL SEROGROUPING/TYPING | Rubella IgM (diagnostic) | FTA-ABS Confirmation |
| E. coli 0157:H7 | Rubeola IgG | VDRL-Cerebral Spinal Fluid Only |
| Haemophilus influenzae | Rubeola IgM (diagnostic) | VIRAL TESTS |
| Neisseria meningitidis | Toxoplasma gondii IgG | Influenza A & B Culture (<i>Designated Providers</i>) |
| Salmonella sp. | Toxoplasma gondii IgM (diagnostic) | Rapid Flu Result (<i>Designated Providers</i>) |
| Shigella sp. | Tularemia Total Antibody | <input type="checkbox"/> Presump. Pos. for Infl. A/B |
| other: | Varicella zoster IgG | <input type="checkbox"/> Presump. Neg. for Infl. A/B |
| MYCOBACTERIAL TESTS | Other: | TOXICOLOGY |
| Mycobacterial Culture/Smear | HIV TESTS | Blood Lead - Pediatric |
| Mycobacterial/Fungal Culture | HIV-1/HIV-2 Antibody Screen (EIA) | Blood Lead - Adult |
| Isolate for Identification | HIV-1 Western Blot (confirmation only) | |
| Amplified M. tuberculosis Direct Test | HIV-Orasure | |

| | |
|-------------------------|----------------------|
| For Laboratory Use Only | LITS #: _____ |
| Lab #: _____ | Date Received: _____ |

| Patient Information | | | |
|--------------------------------------|--|------------------------|---|
| PATIENT LAST NAME / HIV CODE OR ID # | | FIRST NAME | |
| ADDRESS | | | |
| CITY/TOWN | | STATE | ZIP CODE |
| PATIENT MRN # OR UNIQUE IDENTIFIER | | BIRTHDATE (MM/DD/YEAR) | GENDER |
| | | | <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE |

| Billing Information | | No Insurance <input type="checkbox"/> |
|---|--|---------------------------------------|
| RESPONSIBLE PARTY NAME | | PHONE NO. _____ |
| ADDRESS (STREET, TOWN, STATE, ZIP CODE) | | |
| MEDICAID NO. | | MEDICARE NO. |
| INSURANCE COMPANY NAME | | |
| CERT. NO. | | GROUP NO. |
| SUBSCRIBER NAME | | RELATIONSHIP |
| SECONDARY INSURANCE | | |
| CERT. NO. | | GROUP NO. |
| SUBSCRIBER NAME | | RELATIONSHIP |

| SITE | | | |
|---------------------------------------|---|--------------------------------------|--------------------------------|
| <input type="checkbox"/> Cervix | <input type="checkbox"/> Nasopharyngeal | <input type="checkbox"/> Oral | <input type="checkbox"/> Nasal |
| <input type="checkbox"/> Endocervical | <input type="checkbox"/> Rectal | <input type="checkbox"/> Urethra | <input type="checkbox"/> Lung |
| <input type="checkbox"/> Eye | <input type="checkbox"/> Throat | <input type="checkbox"/> Other _____ | |

| | |
|---|--|
| For Laboratory Use Only | Specimen Unsatisfactory |
| <input type="checkbox"/> Transport medium expired | <input type="checkbox"/> Duplicate of # _____ |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> No date of collection |
| | <input type="checkbox"/> QNS/Leaked in transit |
| | <input type="checkbox"/> Overfilled |
| | <input type="checkbox"/> TOTT |