

# Vermont Department of Health Laboratory - Clinical Test Request Form



Mailing Address: PO Box 1125, Burlington, VT 05402-1125

Physical Address: 359 South Park Drive, Colchester VT 05446 • (802) 338-4724 / (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
Date of Collection: _____ Date of Onset: _____	LIMS # _____ Date Received: _____
Time of Collection: _____ ICD Code: _____	

Clinical Lab/Practice Information	Patient Information
Clinical Laboratory/ Practice Name	Last Name _____ First Name _____
Address	Address _____
City/Town _____ State _____ Zip code _____	City/Town _____ State _____ Zip code _____
Telephone Number _____ Fax Number (for a faxed result) _____	MRN# or ID# _____ Specimen ID# _____
Referring Physician Last Name/first Name	Date of Birth (MM/DD/YYYY) _____
NPI # _____	<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
<b>Comments:</b>	<b>Race</b> <input type="checkbox"/> African American or Black <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Multiracial <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other
	<b>Ethnicity</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Other

<input type="checkbox"/> Check if no insurance	Billing Information – Attach Copy of Insurance Card	
Responsible Party Name	Medicaid Number	Medicare Number
Insurance Company Name	ID Number	Group Number
Subscriber Name	Relationship	

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

Specimen Site	Reason for Test
<input type="checkbox"/> Cervix	<input type="checkbox"/> Confirmation/Reference
<input type="checkbox"/> Endocervix	<input type="checkbox"/> Contact/Exposure
<input type="checkbox"/> Lung	<input type="checkbox"/> Diagnostic
<input type="checkbox"/> Nasal Mucosa	<input type="checkbox"/> Hospitalized
<input type="checkbox"/> Nasopharynx	<input type="checkbox"/> Immigrant/Refugee
<input type="checkbox"/> Oral	<input type="checkbox"/> VDHL Request
<input type="checkbox"/> Perianal	<input type="checkbox"/> Immune Status
<input type="checkbox"/> Rectal	<input type="checkbox"/> Outbreak: Facility Name: _____
<input type="checkbox"/> Throat	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Urethra	<input type="checkbox"/> Screen
<input type="checkbox"/> Vaginal	<input type="checkbox"/> Symptomatic
<input type="checkbox"/> Other: _____	

For Laboratory Use Only	
<input type="checkbox"/> Transport medium expired	<input type="checkbox"/> Duplicate of # _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Overfilled <input type="checkbox"/> QNS/Leaked in Transit <input type="checkbox"/> Too Old to Test
VDH EPI notified of receipt of isolate: _____	Shipping Temperature upon arrival: <input type="checkbox"/> Cold <input type="checkbox"/> Room Temp.
VDH EPI notified of preliminary results: _____	Result: _____
VDH EPI notified of final results: _____	Provider notified of preliminary results: _____
	Provider notified of final results: _____

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**PLEASE COMPLETE BACK SIDE**

**Specimen storage condition prior to shipment:** Refrigerated     Frozen     Room Temperature

<b>Bacteriology</b>	<b>Serology</b>
<input type="checkbox"/> Enteric screen (Salmonella, Shigella, E. coli (STEC), Campylobacter, Yersinia, Vibrio) <input type="checkbox"/> Gonorrhea/Chlamydia PCR <input type="checkbox"/> Pertussis species Culture <input type="checkbox"/> Pertussis Culture/PCR (B. pertussis, B. parapertussis, B. holmesii) <input type="checkbox"/> Isolate for Identification: <input type="checkbox"/> Other:	<input type="checkbox"/> Brucella Total Antibody <input type="checkbox"/> Francisella Total Antibody <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 (for Vaccine Response) <input type="checkbox"/> Hepatitis C Antibody Screen <input type="checkbox"/> HIV-1/HIV-2 Antibody and p24 Antigen EIA (serum) <input type="checkbox"/> HIV-1 Oral Fluid <input type="checkbox"/> Interferon Gamma Release Assay (IGRA) Quantiferon TB Gold Plus Tubes incubated at 37°C: <input type="checkbox"/> NO <input type="checkbox"/> YES Date/Time removed from incubator: _____ <input type="checkbox"/> Legionella pneumophila Antigen (urine) <input type="checkbox"/> Measles IgG <input type="checkbox"/> Mumps IgG <input type="checkbox"/> Rubella IgG <input type="checkbox"/> Varicella zoster IgG <input type="checkbox"/> Syphilis - RPR Screen with reflex to RPR Titer and FTA <input type="checkbox"/> Syphilis - VDRL (Cerebral Spinal Fluid Only) <input type="checkbox"/> Measles IgM** <input type="checkbox"/> Rubella IgM** ** Please notify the Epidemiology Unit with any suspect Measles, Mumps, or Rubella cases by calling 802-863-7240 or 1-800-640-4374. <input type="checkbox"/> Other:
<b>Parasitology</b>	
<input type="checkbox"/> Cryptosporidium EIA <input type="checkbox"/> Giardia EIA <input type="checkbox"/> Ova and Parasites (O & P) <input type="checkbox"/> Cyclospora/Cystoisospora <input type="checkbox"/> Pinworm <input type="checkbox"/> Worm for Identification <input type="checkbox"/> Other:	
<b>Biothreat Agents (Call VDHL Prior to Sending)</b>	
<input type="checkbox"/> Bacillus anthracis <input type="checkbox"/> Burkholderia <input type="checkbox"/> Brucella <input type="checkbox"/> Coxiella burnettii <input type="checkbox"/> Francisella tularensis <input type="checkbox"/> Smallpox <input type="checkbox"/> Yersinia pestis <input type="checkbox"/> Other:	
<b>Positive Bacteriology Specimens/Isolates Sent per VDH Requirement</b>	
<b>Use this section if you are submitting a positive CIDT (Culture Independent Diagnostic Test) Specimen.</b>  <input type="checkbox"/> Campylobacter <input type="checkbox"/> Carbapenem-resistant Acinetobacter baumannii (CRAB)* <input type="checkbox"/> Carbapenem-resistant Enterobacterales (CRE)* <input type="checkbox"/> Carbapenem Resistant Pseudomonas aeruginosa (CRPA)* <input type="checkbox"/> E. coli (STEC) <input type="checkbox"/> Haemophilus influenzae typing (Isolated from sterile site) <input type="checkbox"/> Legionella culture <input type="checkbox"/> Listeria monocytogenes <input type="checkbox"/> Neisseria gonorrhoea (culture) <input type="checkbox"/> Neisseria meningitidis (isolated from sterile site) <input type="checkbox"/> Salmonella <input type="checkbox"/> Shigella <input type="checkbox"/> Vibrio <input type="checkbox"/> Other:  * Please include copy of Antimicrobial Susceptibility test results.	<h3 style="text-align: center;">Molecular Virology</h3> <input type="checkbox"/> Influenza A & B PCR: Date Vaccinated: _____ Foreign travel within 10 days of illness onset: <input type="checkbox"/> YES <input type="checkbox"/> NO Location of travel: <input type="checkbox"/> Measles PCR** <input type="checkbox"/> Mumps PCR** <input type="checkbox"/> MPOX PCR <input type="checkbox"/> Norovirus PCR <input type="checkbox"/> RSV (includes SARS-CoV-2 and Influenza A&B) <input type="checkbox"/> SARS-CoV-2 PCR <input type="checkbox"/> Other: ** Please notify the Epidemiology Unit with any suspect Measles, Mumps, or Rubella cases by calling 802-863-7240 or 1-800-640-4374.
<b>Mycobacteriology/Mycology</b>	<b>Positive Virology Specimens Sent per VDH Requirement</b>
<input type="checkbox"/> Candida auris* <input type="checkbox"/> Mycobacterial Culture/Smear <input type="checkbox"/> Mycobacterial/Fungal Culture <input type="checkbox"/> NAAT for Direct Detection of MTB in specimen <input type="checkbox"/> Yeast ID- Invasive, Drug Resistant, or Unidentified Isolate <input type="checkbox"/> Isolate for Identification: _____ <input type="checkbox"/> Other:	<input type="checkbox"/> Arbovirus (list name): _____ <input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> SARS-CoV-2 <input type="checkbox"/> Other: