VERMONT

Department of Health Laboratory

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Vermont Department of Health Laboratory - Clinical Test Request Form

VERMONT DEPARTMENT OF HEALTH

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: _____ Time of Collection: _____ ICD Code: _____	LIMS # Date Received:

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 #			**Gender** ☐ Male ☐ Female ☐ Other		
Comments:			**Race** ☐ African American or Black ☐ American Indian or Alaska Native ☐ Asian ☐ Multiracial ☐ Pacific Islander ☐ White ☐ Unknown ☐ Other **Ethnicity** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Other		

☐ 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

☐ Aspirate site: _____	☐ Fluid-site: _____	☐ Sputum
☐ Biopsy tissue site: _____	☐ Isolate-source: _____	☐ Stool
☐ Blood, Venous	☐ Lymph Node	☐ Swab
☐ Bone	☐ Nasal Swab	☐ Urine
☐ Bronchial Wash	☐ Nasopharyngeal Swab	☐ Other:
☐ Bronchoalveolar Brush	☐ Nasal Wash	
☐ Bronchoalveolar Lavage	☐ Oral Mucosal Transudate (Oral Fluid)	
☐ Cerebral Spinal Fluid	☐ Serum: ☐ Acute ☐ Convalescent	

Specimen Site

☐ Cervix	☐ Perianal
☐ Endocervix	☐ Rectal
☐ Lung	☐ Throat
☐ Nasal Mucosa	☐ Urethra
☐ Nasopharynx	☐ Vaginal
☐ Oral	☐ Other:

Reason for Test

☐ Confirmation/Reference	☐ Immune Status
☐ Contact/Exposure	☐ Outbreak:
☐ Diagnostic	Facility Name: _____
☐ Hospitalized	☐ Pregnancy
☐ Immigrant/Refugee	☐ Screen
☐ VDHL Request	☐ Symptomatic

For Laboratory Use Only

☐ Transport medium expired ☐ Duplicate of # _____ ☐ Overfilled ☐ QNS/Leaked in Transit ☐ Too Old to Test

☐ Other:_____ Shipping Temperature upon arrival: ☐ Cold ☐ Room Temp.

VDH EPI notified of receipt of isolate: _____ Result: _____

VDH EPI notified of preliminary results: _____ Provider notified of preliminary results: _____

VDH EPI notified of final results: _____ Provider notified of final results: _____

PLEASE COMPLETE BACK SIDE

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

Bacteriology

- ☐ Enteric screen (Salmonella, Shigella, E. coli (STEC), Campylobacter, Yersinia, Vibrio)
- ☐ Gonorrhea/Chlamydia PCR
- ☐ Pertussis species Culture
- ☐ Pertussis Culture/PCR (B. pertussis, B. parapertussis, B. holmesii)
- ☐ Isolate for Identification:
- ☐ Other:

Parasitology

- ☐ Cryptosporidium EIA ☐ Giardia EIA
- ☐ Ova and Parasites (O & P) ☐ Cyclospora/Cystoisospora
- ☐ Pinworm
- ☐ Worm for Identification
- ☐ Other:

Biothreat Agents (Call VDHL Prior to Sending)

- ☐ Bacillus anthracis ☐ Burkholderia
- ☐ Brucella ☐ Coxiella burnettii
- ☐ Francisella tularensis ☐ Smallpox
- ☐ Yersinia pestis
- ☐ Other:

Positive Bacteriology Specimens/Isolates Sent per VDH Requirement

Use this section if you are submitting a positive CIDT (Culture Independent Diagnostic Test) Specimen.

- ☐ Campylobacter
- ☐ Carbapenem-resistant Acinetobacter baumannii (CRAB)*
- ☐ Carbapenem-resistant Enterobacterales (CRE)*
- ☐ Carbapenem Resistant Pseudomonas aeruginosa (CRPA)*
- ☐ E. coli (STEC)
- ☐ Haemophilus influenzae typing (Isolated from sterile site)
- ☐ Legionella culture
- ☐ Listeria monocytogenes
- ☐ Neisseria gonorrhea (culture)
- ☐ Neisseria meningitidis (isolated from sterile site)
- ☐ Salmonella
- ☐ Shigella
- ☐ Vibrio
- ☐ Other:

* Please include copy of Antimicrobial Susceptibility test results.

Mycobacteriology/Mycology

- ☐ Candida auris*
- ☐ Mycobacterial Culture/Smear
- ☐ Mycobacterial/Fungal Culture
- ☐ NAAT for Direct Detection of MTB in specimen
- ☐ Yeast ID- Invasive, Drug Resistant, or Unidentified Isolate
- ☐ Isolate for Identification: _____
- ☐ Other:

Serology

- ☐ Brucella Total Antibody
- ☐ Francisella Total Antibody
- ☐ Hepatitis B Panel (Surface Antigen, Surface Antibody, Core Total Antibody)
- ☐ Hepatitis B Surface Antigen
- ☐ Hepatitis B Core Total Antibody
- ☐ Hepatitis B Surface Antibody (for Vaccine Response)
- ☐ Hepatitis C Antibody Screen
- ☐ HIV-1/HIV-2 Antibody and p24 Antigen EIA (serum)
- ☐ HIV-1 Oral Fluid
- ☐ Interferon Gamma Release Assay (IGRA) Quantiferon TB Gold Plus
  Tubes incubated at 37˚C: ☐ NO
  ☐ YES
  Date/Time removed from incubator: _____
- ☐ Legionella pneumophila Antigen (urine)
- ☐ Measles IgG
- ☐ Mumps IgG
- ☐ Rubella IgG
- ☐ Varicella zoster IgG
- ☐ Syphilis - RPR Screen with reflex to RPR Titer and FTA
- ☐ Syphilis - VDRL (Cerebral Spinal Fluid Only)
- ☐ Measles IgM**
- ☐ 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.

- ☐ Other:

Molecular Virology

- ☐ Influenza A & B PCR:
  Date Vaccinated: _____
  Foreign travel within 10 days of illness onset: ☐ YES ☐ NO
  Location of travel:
- ☐ Measles PCR**
- ☐ Mumps PCR**
- ☐ MPOX PCR
- ☐ Norovirus PCR
- ☐ RSV (includes SARS-CoV-2 and Influenza A&B)
- ☐ SARS-CoV-2 PCR
- ☐ Other:

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Positive Virology Specimens Sent per VDH Requirement

- ☐ Arbovirus (list name): _____
- ☐ Influenza A
- ☐ Influenza B
- ☐ SARS-CoV-2
- ☐ Other: