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:___________	Lab/LIMS # Date Received:
Time of Collection:___________ ICD Code: ___________	LITS #:

Clinical Laboratory/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			MRN# or ID#	Specimen ID#	
Referring Physician Last Name/first Name			Date of Birth (MM/DD/YYYY)	Gender ☐ Male ☐ Female	
NPI #			Travel History (within past 6 months)	Date Vaccinated for Influenza	
Comments			TST History (For QFT Test Only) Date: Result mm:	BCG Vaccinated (For QFT Test Only) ☐ Yes ☐ No ☐ Unknown	

☐ Check if No Insurance	Billing Information	
Responsible Party Name	Medicaid Number	Medicare Number
Insurance Company Name	ID Number	Group Number
Subscriber Name	Relationship	
Secondary Insurance Company Name	ID Number	Group Number
Subscriber Name	Relationship	

Specimen Source:

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

Specimen Site

- ☐ Abdomen
- ☐ Cervix
- ☐ Endocervix
- ☐ Lung
- ☐ Nasal Mucosa
- ☐ Other:
- ☐ Nasopharynx
- ☐ Oral
- ☐ Rectal
- ☐ Throat
- ☐ Vaginal

Reason for Test

- ☐ Confirmation/Reference
- ☐ Contact/Exposure
- ☐ Diagnostic
- ☐ Hospitalized
- ☐ Immigrant/Refugee
- ☐ Other:
- ☐ Immune Status
- ☐ Pregnancy
- ☐ Screen
- ☐ Symptomatic
- ☐ VDHL Request

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.

Epidemiology notified of receipt of isolate:___________ Result:___________________________

Epidemiology notified of preliminary results:___________ Provider notified of preliminary results:___________

Epidemiology notified of final results: ___________ Provider notified of final results:___________

Laboratory Examination Requested

Bacteriology	Serology
☐ Carbapenem Resistant Enterobacteriaceae	☐ Brucella Total Antibody
☐ Carbapenem Resistant Pseudomonas aeruginosa	☐ Francisella Total Antibody
☐ Enteric Screen (Salmonella, Shigella, E. coli Shiga-like toxin, Campylobacter, Yersinia)	☐ Hepatitis B Panel (Surface Antigen, Surface Antibody, Core, Total Antibody)
☐ E. coli Shiga Toxin	☐ Hepatitis B Surface Antigen
☐ Gonorrhea culture	☐ Hepatitis B Core Total Antibody
☐ Gonorrhea/Chlamydia Amplified	☐ Hepatitis B Surface Antibody (for Vaccine Response)
☐ Legionella pneumophila Antigen (urine)	☐ Hepatitis C Antibody Screen
☐ Pertussis species Culture	☐ HIV-1/HIV-2 Antibody and p24 Antigen EIA (serum)
☐ Pertussis Culture/PCR (PCR includes B. pertussis, B. parapertussis, B. holmseii)	☐ HIV-1 Oral Fluid
☐ Isolate for Identification:	☐ IGRA: Quantiferon-TB Gold In Tube Test (MTB-IFN-γ) **
☐ Other:	☐ Legionella pneumophila IgG
Bacterial Typing/Fingerprinting	☐ Mumps IgG
☐ Campylobacter	☐ Rubella IgG
☐ E. coli O157:H7	☐ Rubella IgM (Diagnostic)
☐ Shiga Toxin Positive E. coli (STEC)	☐ Rubeola IgG
☐ Haemophilus influenza	☐ Rubeola IgM (Diagnostic)
☐ Listeria species	☐ Syphillis - RPR Screen
☐ Neisseria meningitidis	☐ Syphillis - FTA-ABS Confirmation
☐ Salmonella species	☐ Syphillis - VDRL (Cerebral Spinal Fluid Only)
☐ Shigella species	☐ Varicella zoster IgG
☐ Other:	☐ Other:
Mycobacteriology	**Toxicology**
☐ Mycobacterial Culture/Smear	☐ Other (please specify):
☐ Mycobacterial/Fungal Culture	
☐ NAAT for Direct Detection of MTB in specimen	
☐ Isolate for Identification	**Virology**
☐ Isolate for Genotyping	☐ Influenza A & B PCR
Parasitology	☐ Mumps PCR *
☐ Cryptosporidium EIA	☐ Zika
☐ Giardia EIA	☐ Other:
☐ Ova and Parasites (O & P)	**Comments**
☐ Acid Fast Stain for Cyclospora	
☐ Pinworm	
☐ Worm for Identification	
☐ Other:	

***** Requires prior approval from the Epidemiology Unit, call 802-863-7240 or 1-800-640-4374

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

NOTE: For the **MTB-INF-γ**, the patient must have at least one of the risk factors listed below **BEFORE** testing will be performed at the VDHL.

- 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

A copy of this form can be found at www.healthvermont.gov/lab/forms