# 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 or (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 (print clearly) | | |
|---|---|---|---|---|---|
| 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
- ☐ Carbapenem Resistant Enterobacteriaceae
- ☐ Carbapenem Resistant Pseudomonas aeruginosa
- ☐ Enteric Screen (Salmonella, Shigella, E. coli Shiga-like toxin, Campylobacter, Yersinia)
- ☐ E. coli Shiga Toxin
- ☐ Gonorrhea culture
- ☐ Gonorrhea/Chlamydia Amplified
- ☐ Legionella pneumophila Antigen (urine)
- ☐ Pertussis species Culture
- ☐ Pertussis Culture/PCR (PCR includes B. pertussis, B. parapertussis, B. holmseii)
- ☐ Isolate for Identification:
- ☐ Other:

## Bacterial Typing/Fingerprinting
- ☐ Campylobacter
- ☐ E. coli O157:H7
- ☐ Shiga Toxin Positive E. coli (STEC)
- ☐ Haemophilus influenza
- ☐ Listeria species
- ☐ Neisseria meningitidis
- ☐ Salmonella species
- ☐ Shigella species
- ☐ Other:

## Mycobacteriology
- ☐ Mycobacterial Culture/Smear
- ☐ Mycobacterial/Fungal Culture
- ☐ NAAT for Direct Detection of MTB in specimen
- ☐ Isolate for Identification
- ☐ Isolate for Genotyping

## Parasitology
- ☐ Cryptosporidium EIA
- ☐ Giardia EIA
- ☐ Ova and Parasites (O & P)
- ☐ Acid Fast Stain for Cyclospora
- ☐ Pinworm
- ☐ Worm 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
- ☐ IGRA: Quantiferon-TB Gold In Tube Test (MTB-IFN-γ) **
- ☐ Legionella pneumophila IgG
- ☐ Mumps IgG
- ☐ Rubella IgG
- ☐ Rubella IgM (Diagnostic)
- ☐ Rubeola IgG
- ☐ Rubeola IgM (Diagnostic)
- ☐ Syphillis - RPR Screen
- ☐ Syphillis - FTA-ABS Confirmation
- ☐ Syphillis - VDRL (Cerebral Spinal Fluid Only)
- ☐ Varicella zoster IgG
- ☐ Other:

## Toxicology
- ☐ Other (please specify):

## Virology
- ☐ Influenza A & B PCR
- ☐ Mumps PCR *
- ☐ Zika
- ☐ Other:

## Comments

* 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.