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 Type

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

Specimen Site		Reason for Test	
☐ Cervix	☐ Nasopharynx	☐ Screen	☐ Immune Status
☐ Endocervical	☐ Oral	☐ Diagnostic	☐ Immigrant/Refugee
☐ Lung	☐ Rectal	☐ Confirmation/Reference	☐ Pregnancy
☐ Nares	☐ Throat	☐ Contact/Exposure	☐ VDHL Request
☐ Nasal Mucosa	☐ Urethra	☐ Hospitalized	
☐ Other:		☐ Other:	

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

- ☐ Enteric Screen (Salmonella, Shigella, E. coli Shiga-like Toxin, Campylobacter, Yersinia)
- ☐ E. coli Shiga-like Toxin
- ☐ Gonorrhea Culture
- ☐ Gonorrhea/Chlamydia Amplified
- ☐ Legionella pneumophila Culture
- ☐ Legionella pneumophila Antigen (urine)
- ☐ Pertussis spp. 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 sp.
- ☐ Neisseria meningitidis
- ☐ Salmonella sp.
- ☐ Shigella sp.
- ☐ Other:

Mycobacteriology

- ☐ Mycobacterial Culture/ Smear
- ☐ Mycobacterial/Fungal Culture
- ☐ Amplified M. tuberculosis Direct Test
- ☐ Isolate for Identification
- ☐ Isolate for Genotyping

Parasitology

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

Serology

- ☐ Brucella and 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
- ☐ HIV-1: Confirm Positive Rapid HIV-1 Test
- ☐ 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

- ☐ Blood Lead - Pediatric
- ☐ Blood Lead - Adult

Virology

- ☐ Influenza A & B PCR
- ☐ Mumps PCR *
- ☐ 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 **http://healthvermont.gov/**