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 Vermont Department of Health Epidemiology			Last Name	First Name	
Address 108 Cherry St. Suite 305			Address		
City/Town Burlington	State VT	Zip code 05401	City/Town	State	Zip code
Telephone Number 802-863-7240	Fax Number (for a faxed result) 802-951-4061		MRN# or ID#	Specimen ID#	
Referring Physician Last Name/first Name Infectious Disease Epidemiology			Date of Birth (MM/DD/YYYY)		
NPI #			Gender ☐ Male ☐ Female ☐ Choose Not to Disclose		
Comments			☐ Gender Identity (please specify): _____		

☐ Check if No Insurance	Billing Information – Attach Copy of Insurance Card	
Responsible Party Name N/A	Medicaid Number N/A	Medicare Number N/A
Insurance Company Name N/A	ID Number N/A	Group Number N/A
Subscriber Name N/A	Relationship N/A	
Secondary Insurance Company Name N/A	ID Number N/A	Group Number N/A
Subscriber Name N/A	Relationship N/A	

Specimen Source

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

Specimen Site		Reason for Test	
☐ Cervix	☐ Perianal	☐ Confirmation/Reference	☐ Immune Status
☐ Endocervix	☐ Rectal	☐ Contact/Exposure	■ Outbreak
☐ Lung	☐ Throat	☐ Diagnostic	☐ Pregnancy
☐ Nasal Mucosa	☐ Urethra	☐ Hospitalized	☐ Screen
☐ Nasopharynx	☐ Vaginal	☐ Immigrant/Refugee	☐ Symptomatic
☐ Oral	☐ Other:	☐ VDHL Request	☐ 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 (STEC), Campylobacter, Yersinia, Vibrio)
- ☐ Gonorrhea/Chlamydia PCR
- ☐ Pertussis species Culture
- ☐ Pertussis Culture/PCR (PCR includes B. pertussis, B. parapertussis, B. holmseii)
- ☐ Isolate for Identification:
- ☐ Other:

Biothreat Agents (Call VDHL Prior to Sending)

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

Organisms Sent per VDH Requirement

- ☐ Arboviruses (list name): _____
- ☐ Campylobacter
- ☐ Candida auris
- ☐ Carbapenem-resistant Acinetobacter baumannii (CRAB)*
- ☐ Carbapenem-resistant Enterobacteriaceae (CRE)*
- ☐ Carbapenem Resistant Pseudomonas aeruginosa (CRPA)*
- ☐ E. coli (STEC)
- ☐ Haemophilus influenza typing (Isolated from sterile site)
- ☐ Influenza (novel strains only)
- ☐ Leptospira species
- ☐ Listeria monocytogenes
- ☐ Mycobacterium tuberculosis complex
- ☐ Neisseria meningitidis (isolated from sterile site)
- ☐ Salmonella
- ☐ Shigella
- ☐ Vibrio
- ☐ Other:

Mycobacteriology

- ☐ Mycobacterial Culture/Smear
- ☐ Mycobacterial/Fungal Culture
- ☐ NAAT for Direct Detection of MTB in specimen
- ☐ Isolate for Identification: _____
- ☐ Other:

Comments:

Parasitology

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

Serology

- ☐ Brucella Total Antibody
- ☐ Dengue IgM
- ☐ 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: _____
- ☐ Legionella pneumophila Antigen (urine)
- ☐ Measles IgG
- ☐ Measles IgM**
- ☐ Mumps IgG
- ☐ Rubella IgG
- ☐ Rubella IgM**
- ☐ Syphilis - RPR Screen with reflex to RPR Titer and FTA
- ☐ Syphilis - FTA-ABS confirmation (includes RPR Titer)
- ☐ Syphilis - VDRL (Cerebral Spinal Fluid Only)
- ☐ Varicella zoster IgG
- ☐ Zika IgM/PCR (PCR includes Dengue, Chikungunya, Zika)
- ☐ Other:

Toxicology

- ☐ Other:

Virology

- ☐ Influenza A & B PCR:
  Date Vaccinated: _____
  Foreign travel within 10 days of illness onset: ☐ YES ☐ NO
  Location of travel:
- ☐ Measles PCR**
- ☐ Mumps PCR**
- ☒ Norovirus PCR
- ☐ Other:

* Please include copy of Antimicrobial Susceptibility test results.
** Please notify the Epidemiology Unit with any suspect Measles, Mumps, or Rubella cases by calling 802-863-7240 or 1-800-640-4374.