

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

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 _____ <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Choose Not to Disclose
Comments	<input type="checkbox"/> Gender Identity (please specify): _____

<input type="checkbox"/> 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	
Secondary Insurance Company Name	ID Number	Group Number
Subscriber Name	Relationship	

Specimen Source		
<input type="checkbox"/> Aspirate site: _____ <input type="checkbox"/> Biopsy tissue site: _____ <input type="checkbox"/> Blood, Venous <input type="checkbox"/> Bone <input type="checkbox"/> Bronchial Wash <input type="checkbox"/> Bronchoalveolar Brush <input type="checkbox"/> Bronchoalveolar Lavage <input type="checkbox"/> Cerebral Spinal Fluid	<input type="checkbox"/> CIDT (Culture Independent Diagnostic Test)-source: _____ <input type="checkbox"/> Fluid-site: _____ <input type="checkbox"/> Isolate-source: _____ <input type="checkbox"/> Lymph Node <input type="checkbox"/> Nasal Swab <input type="checkbox"/> Nasopharyngeal Swab <input type="checkbox"/> Nasal Wash <input type="checkbox"/> Oral Mucosal Transudate (Oral Fluid)	<input type="checkbox"/> Serum: <input type="checkbox"/> Acute <input type="checkbox"/> Convalescent <input type="checkbox"/> Sputum <input type="checkbox"/> Stool <input type="checkbox"/> Swab <input type="checkbox"/> Urine <input type="checkbox"/> Other: _____

Specimen Site	Reason for Test
<input type="checkbox"/> Cervix <input type="checkbox"/> Endocervix <input type="checkbox"/> Lung <input type="checkbox"/> Nasal Mucosa <input type="checkbox"/> Nasopharynx <input type="checkbox"/> Oral <input type="checkbox"/> Perianal <input type="checkbox"/> Rectal <input type="checkbox"/> Throat <input type="checkbox"/> Urethra <input type="checkbox"/> Vaginal <input type="checkbox"/> Other: _____	<input type="checkbox"/> Confirmation/Reference <input type="checkbox"/> Contact/Exposure <input type="checkbox"/> Diagnostic <input type="checkbox"/> Hospitalized <input type="checkbox"/> Immigrant/Refugee <input type="checkbox"/> VDHL Request <input type="checkbox"/> Immune Status <input type="checkbox"/> Outbreak <input type="checkbox"/> Pregnancy <input type="checkbox"/> Screen <input type="checkbox"/> Symptomatic <input type="checkbox"/> Other: _____

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<input type="checkbox"/> Transport medium expired <input type="checkbox"/> Duplicate of # _____ <input type="checkbox"/> Overfilled <input type="checkbox"/> QNS/Leaked in Transit <input type="checkbox"/> Too Old to Test <input type="checkbox"/> Other: _____ Shipping Temperature upon arrival: <input type="checkbox"/> Cold <input type="checkbox"/> 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	Parasitology
<input type="checkbox"/> Enteric screen (Salmonella, Shigella, E. coli (STEC), Campylobacter, Yersinia, Vibrio) <input type="checkbox"/> Gonorrhea/Chlamydia PCR <input type="checkbox"/> Pertussis species Culture <input type="checkbox"/> Pertussis Culture/PCR (PCR includes B. pertussis, B. paraptussis, B. holmseii) <input type="checkbox"/> Isolate for Identification: <input type="checkbox"/> Other:	<input type="checkbox"/> Cryptosporidium EIA <input type="checkbox"/> Giardia EIA <input type="checkbox"/> Ova and Parasites (O & P) <input type="checkbox"/> Acid Fast Stain for Cyclospora <input type="checkbox"/> Pinworm <input type="checkbox"/> Worm for Identification <input type="checkbox"/> Other:
Biothreat Agents (Call VDHL Prior to Sending)	Serology
<input type="checkbox"/> Bacillus anthracis <input type="checkbox"/> Brucella <input type="checkbox"/> Francisella tularensis <input type="checkbox"/> Yersinia pestis <input type="checkbox"/> Other: <input type="checkbox"/> Burkholderia <input type="checkbox"/> Coxiella burnettii <input type="checkbox"/> Smallpox	<input type="checkbox"/> Brucella Total Antibody <input type="checkbox"/> Dengue IgM <input type="checkbox"/> Francisella Total Antibody <input type="checkbox"/> Hepatitis B Panel (Surface Antigen, Surface Antibody, Core Total Antibody) <input type="checkbox"/> Hepatitis B Surface Antigen <input type="checkbox"/> Hepatitis B Core Total Antibody <input type="checkbox"/> Hepatitis B Surface Antibody (for Vaccine Response) <input type="checkbox"/> Hepatitis C Antibody Screen <input type="checkbox"/> HIV-1/HIV-2 Antibody and p24 Antigen EIA (serum) <input type="checkbox"/> HIV-1 Oral Fluid <input type="checkbox"/> Interferon Gamma Release Assay (IGRA) Quantiferon TB Gold Plus Tubes incubated at 37°C: <input type="checkbox"/> NO <input type="checkbox"/> YES Date/Time: _____ <input type="checkbox"/> Legionella pneumophila Antigen (urine) <input type="checkbox"/> Measles IgG <input type="checkbox"/> Measles IgM** <input type="checkbox"/> Mumps IgG <input type="checkbox"/> Rubella IgG <input type="checkbox"/> Rubella IgM** <input type="checkbox"/> Syphilis - RPR Screen with reflex to RPR Titer and FTA <input type="checkbox"/> Syphilis - FTA-ABS confirmation (includes RPR Titer) <input type="checkbox"/> Syphilis - VDRL (Cerebral Spinal Fluid Only) <input type="checkbox"/> Varicella zoster IgG <input type="checkbox"/> Zika IgM/PCR (PCR includes Dengue, Chikungunya, Zika) <input type="checkbox"/> Other:
Organisms Sent per VDH Requirement	
<input type="checkbox"/> Arboviruses (list name): _____ <input type="checkbox"/> Campylobacter <input type="checkbox"/> Candida auris <input type="checkbox"/> Carbapenem-resistant Acinetobacter baumannii (CRAB)* <input type="checkbox"/> Carbapenem-resistant Enterobacteriaceae (CRE)* <input type="checkbox"/> Carbapenem Resistant Pseudomonas aeruginosa (CRPA)* <input type="checkbox"/> E. coli (STEC) <input type="checkbox"/> Haemophilus influenza typing (Isolated from sterile site) <input type="checkbox"/> Influenza (novel strains only) <input type="checkbox"/> Leptospira species <input type="checkbox"/> Listeria monocytogenes <input type="checkbox"/> Mycobacterium tuberculosis complex <input type="checkbox"/> Neisseria meningitidis (isolated from sterile site) <input type="checkbox"/> Salmonella <input type="checkbox"/> Shigella <input type="checkbox"/> Vibrio <input type="checkbox"/> Other:	
Mycobacteriology	
<input type="checkbox"/> Mycobacterial Culture/Smear <input type="checkbox"/> Mycobacterial/Fungal Culture <input type="checkbox"/> NAAT for Direct Detection of MTB in specimen <input type="checkbox"/> Isolate for Identification: _____ <input type="checkbox"/> Other:	
Comments:	Toxicology
	<input type="checkbox"/> Other:
	Virology
	<input type="checkbox"/> Influenza A & B PCR: Date Vaccinated: _____ Foreign travel within 10 days of illness onset: <input type="checkbox"/> YES <input type="checkbox"/> NO Location of travel: <input type="checkbox"/> Measles PCR** <input type="checkbox"/> Mumps PCR** <input type="checkbox"/> Norovirus PCR <input type="checkbox"/> 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.