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			**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** ☐ Male ☐ Female ☐ Other		
Comments:			**Race** ☐ African American or Black ☐ American Indian or Alaska Native ☐ Asian ☐ Multiracial ☐ Pacific Islander ☐ White ☐ Unknown ☐ Other **Ethnicity** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Other		

☐ 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**	

Specimen Source

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

Specimen Site

☐ Cervix	☐ Perianal
☐ Endocervix	☐ Rectal
☐ Lung	☐ Throat
☐ Nasal Mucosa	☐ Urethra
☐ Nasopharynx	☐ Vaginal
☐ Oral	☐ Other:

Reason for Test

☐ Confirmation/Reference	☐ Immune Status
☐ Contact/Exposure	☐ Outbreak:
☐ Diagnostic	Facility Name: _____
☐ Hospitalized	☐ Pregnancy
☐ Immigrant/Refugee	☐ Screen
☐ VDHL Request	☐ Symptomatic

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.

VDH EPI notified of receipt of isolate: _____ Result: _____

VDH EPI notified of preliminary results: _____ Provider notified of preliminary results: _____

VDH EPI notified of final results: _____ Provider notified of final results: _____

PLEASE COMPLETE BACK SIDE

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Bacteriology

- ☐ Enteric screen (Salmonella, Shigella, E. coli (STEC), Campylobacter, Yersinia, Vibrio)
- ☐ Gonorrhea/Chlamydia PCR
- ☐ Pertussis species Culture
- ☐ Pertussis Culture/PCR (B. pertussis, B. parapertussis, B. holmseii)
- ☐ Isolate for Identification:
- ☐ Other:

Parasitology

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

Biothreat Agents (Call VDHL Prior to Sending)

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

Specimens/Isolates sent per VDH Requirement

If the specimen being submitting is from a CIDT (Culture Independent Diagnostic Test), please use this section

- ☐ 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:

Serology

- ☐ Brucella Total Antibody
- ☐ Francisella Total Antibody
- ☐ Dengue IgM
- ☐ Hepatitis B Panel (Surface Antigen, Surface Antibody, Core Total Antibody)
- ☐ Hepatitis B Surface Antigen
- ☐ 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
- ☐ Other:

Molecular Virology

- ☐ Arbovirus PCR (Dengue, Chikungunya, Zika)
- ☐ 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
- ☐ SARS-CoV-2 (Coronavirus 2019-nCoV)
- ☐ Other:

Additional COVID-19 Questions

Event name: _____

First Test?	☐ Yes	☐ No	☐ Unknown
Employed in Healthcare?	☐ Yes	☐ No	☐ Unknown
Symptomatic as defined by CDC?	☐ Yes	☐ No	☐ Unknown
If Yes, Date of Onset: _____			
Hospitalized?	☐ Yes	☐ No	☐ Unknown
ICU?	☐ Yes	☐ No	☐ Unknown
Congregate care resident?	☐ Yes	☐ No	☐ Unknown
Pregnant?	☐ Yes	☐ No	☐ Unknown

* 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.