

	<b>ENTERIC BACTERIOLOGY</b> <b>PUBLIC HEALTH LABORATORY TEST REQUEST</b>	<b>FOR LAB USE ONLY</b>
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**DATE\*** (MM/DD/YYYY)::

**\*REQUIRED INFORMATION**

<b>1. PATIENT INFORMATION</b>			
PATIENT LAST NAME*:		PATIENT FIRST NAME*:	
DATE OF BIRTH*(MM/DD/YYYY):	Sex*: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	PATIENT ID#/MEDICAL RECORD#:	
ADDRESS:	CITY:	STATE:	ZIP:
TELEPHONE:	PHYSICIAN (if other than submitter)		Physician's pager/cell:

<b>2. SUBMITTER INFORMATION</b>			
NAME OF SUBMITTING HOSPITAL, LABORATORY, or OTHER FACILITY Etc.*:		PROVIDER ID#:	
PRIMARY CONTACT or PHYSICIAN- LAST NAME*:		FIRST NAME*:	
ADDRESS*:			
CITY*:		STATE*:	ZIP*:
TELEPHONE*:	Pager/Cell*:	Fax:	EMAIL:

<b>3. SPECIMEN INFORMATION</b>			
DATE OF COLLECTION* (MM/DD/YYYY):		TIME OF COLLECTION*[00:00]: <input type="checkbox"/> <input type="checkbox"/> AM <input type="checkbox"/> <input type="checkbox"/> PM (where applicable)	
Reason for submission*	<input type="checkbox"/> DIAGNOSTIC <input type="checkbox"/> CONFIRMATORY <input type="checkbox"/> OUTBREAK <input type="checkbox"/> DOHMH REQUEST (if checked complete A & B below)		
A. DOHMH Bureau	<input type="checkbox"/> BCD <input type="checkbox"/> BOI <input type="checkbox"/> OEI <input type="checkbox"/> OTHER (specify):		DOHMH EVENT CODE:
B. DOHMH Contact	Last Name:	First Name:	
Is this submission for referral?*	<input type="checkbox"/> NO <input type="checkbox"/> YES (IF YES CHECK ONE): <input type="radio"/> NYS <input type="radio"/> CDC <input type="radio"/> OTHER (specify):		
Specimen type*	<input type="checkbox"/> Primary Specimen <input type="checkbox"/> Isolate : Lab ID		METHOD:
Specimen source*	<input type="checkbox"/> Stool <input type="checkbox"/> Rectal <input type="checkbox"/> Other (specify):		
Additional Comments			

<b>4. TEST(S) REQUESTED*</b>		
<input type="checkbox"/> Bacillus cereus Identification	<input type="checkbox"/> Salmonella Typhi ID & Serotyping (isolate)	<input type="checkbox"/> Shigella spp. ID & Serotyping (Primary specimen-DOHMH request only)
<input type="checkbox"/> Campylobacter Identification	<input type="checkbox"/> Salmonella Typhi ID & Serotyping (Primary specimen-DOHMH request only)	<input type="checkbox"/> S. aureus ID (enterotoxigenic)
<input type="checkbox"/> Clostridium perfringens Identification	<input type="checkbox"/> Salmonella ID & Serotyping (other than Typhi)(isolate)	<input type="checkbox"/> SHIGA Toxin Assay I & II (E. coli 0157:H7/other EHEC)
<input type="checkbox"/> E. coli 0157:H7/Other EHEC Identification	<input type="checkbox"/> Salmonella ID & Serotyping (other than Typhi) (Primary specimen-DOHMH request only)	<input type="checkbox"/> Vibrio cholerae & Non-V. cholerae ID
<input type="checkbox"/> Enteric pathogen profile (Salmonella, Shigella, Yersinia, Campylobacter, EHEC)	<input type="checkbox"/> Salmonella/Shigella ID (Primary specimen-DOHMH request only)	<input type="checkbox"/> Yersinia enterocolitica ID
<input type="checkbox"/> ID of Miscellaneous Enterobacteriaceae	<input type="checkbox"/> Shigella spp. ID & Serotyping (isolate)	<input type="checkbox"/> Other (specify):

LTR\_MIC02F\_109

\*Failure to provide the required information or any discrepancy relating to the specimen submitted, may result in an inability to test or a delay in the release of test results.