

	GENERAL BACTERIOLOGY PUBLIC HEALTH LABORATORY TEST REQUEST	FOR LAB USE ONLY
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DATE* (MM/DD/YYYY): *** Required information**

1. PATIENT INFORMATION			
PATIENT LAST NAME*:		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:	

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

3. SPECIMEN INFORMATION			
DATE OF COLLECTION* (MM/DD/YYYY)		TIME OF COLLECTION* (00:00)[where applicable] <input type="checkbox"/> AM <input type="checkbox"/> PM	
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):		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"/> Isolate <input type="checkbox"/> Primary Specimen <input type="checkbox"/> Slide		
Specimen source*	<input type="checkbox"/> Anorectal <input type="checkbox"/> Blood/serum <input type="checkbox"/> **Body fluid <input type="checkbox"/> CSF <input type="checkbox"/> Genital <input type="checkbox"/> **Respiratory <input type="checkbox"/> **Nasopharyngeal <input type="checkbox"/> OCME Workup <input type="checkbox"/> Rectal <input type="checkbox"/> Throat <input type="checkbox"/> **Tissue <input type="checkbox"/> Urine <input type="checkbox"/> Wound <input type="checkbox"/> **Other **Specify type		
Additional comments			

4. TEST(S) REQUESTED*		
<input type="checkbox"/> Antibiotic Susceptibility Test (specify antibiotic/s) (i.e. SXT, AM, P)		
<input type="checkbox"/> Bacterial isolate for ID/Confirmation (indicate lab ID if available):		
<input type="checkbox"/> B. pertussis DFA	<input type="checkbox"/> H. influenzae Serotyping	<input type="checkbox"/> N. meningitidis ID/Confirmation
<input type="checkbox"/> B. pertussis ID/Confirmation	<input type="checkbox"/> Legionella spp. Confirmation & Serotyping	<input type="checkbox"/> Routine Culture (OCME only)
<input type="checkbox"/> Campylobacter/Helicobacter spp. ID/Confirmation	<input type="checkbox"/> Legionella spp. Culture	<input type="checkbox"/> VISA/VRSA Confirmation
<input type="checkbox"/> C. diphtheriae ID/Confirmation	<input type="checkbox"/> Legionella Urinary Antigen	<input type="checkbox"/> Other (specify):
<input type="checkbox"/> CT/GC NAAT (DOHMH ONLY)	<input type="checkbox"/> L. monocytogenes Serotyping	<input type="checkbox"/> Other (specify):
<input type="checkbox"/> CT/GC NAAT r/o LGV (anorectal only) (DOHMH ONLY)	<input type="checkbox"/> MRSA Confirmation	
<input type="checkbox"/> H. ducreyi Culture	<input type="checkbox"/> N. gonorrhoeae Culture	

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*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.