

# Upper Peninsula Laboratory Test Requisition

## Michigan Department of Community Health - Bureau of Laboratories

ATDC Building 1402 East Sharon Avenue PO Box 38 Houghton Michigan 49931-0038  
 Phone: 906-487-3011 Fax: 906-487-3682 HTTP://www.Michigan.gov/mdchlab

Date Received at MDCH										MDCH Sample #														
<b>AGENCY - SUBMITTER INFORMATION</b>										<b>ENTER EPIC/STARLIMS CODE IF KNOWN</b>														
Return Results to:										<input type="checkbox"/> FP Phone (24/7)														
										<input type="checkbox"/> STD Fax														
CONTACT PERSON/ ATTENDING PHYSICIAN/ PROVIDER NAME:										NATIONAL PROVIDER IDENTIFIER:														
SUBMITTER'S PATIENT NUMBER - IF APPLICABLE																								
<b>PATIENT INFORMATION - NAME (LAST, FIRST, MIDDLE INITIAL OR UNIQUE IDENTIFIER) Must Match Specimen Label Exactly</b>																								
PATIENT'S CITY of RESIDENCE										ZIP CODE					GENDER					<input type="checkbox"/> Female <input type="checkbox"/> Male				
RACE		<input type="checkbox"/> Black/AA <input type="checkbox"/> White <input type="checkbox"/> Native American or Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian/PI <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify):																						
ETHNICITY		Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown								MEDICAID or PLAN FIRST NUMBER														
		Arab Descent <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown																						
DATE OF BIRTH				M	M	D	D	Y	Y	ONSET DATE				M	M	D	D	Y	Y	Y	Y			
SUBMITTER'S SPECIMEN NUMBER - IF APPLICABLE																								

### SPECIMEN INFORMATION - INDICATE TEST REQUESTED

- 0500  Enteric Culture
- 0673  *Chlamydia trachomatis* (non-culture)<sup>1</sup>
- 0801  *Neisseria gonorrhoeae* - Isolation
- 0851  *Neisseria* - Culture Identification
- 2100  USR Test (Syphilis Serology)
- 2951  \*Norovirus PCR
- 2961  \*Bacterial Typing by Pulse Field Gel Electrophoresis - Specify Organism: \_\_\_\_\_
- 9999  \*Other - Specify: \_\_\_\_\_

(\*) INDICATES PRIOR APPROVAL REQUIRED

DATE COLLECTED		M	M	D	D	Y	Y	Y	Y	TIME COLLECTED						<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	
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### INDICATE SPECIMEN SOURCE BELOW

- Cervix       Culture       Serum       Stool       Urethra       Urine
- Other - Specify: \_\_\_\_\_

### INDICATE TEST REASON BELOW

- Diagnosis       Surveillance       Suspected Outbreak - Specify: \_\_\_\_\_
- Other - Specify: \_\_\_\_\_

Sexually Transmitted Diseases - Reason for Testing (See reverse for definitions)

- Symptoms       Infected Partner       Partner Risk       Prenatal Visit       Retest
- Age Recommended       Plan First Client       Medicaid (Not Plan First)       History of STD (< 3 years)

OUTBREAK IDENTIFIER (Foodborne ONLY - If Applicable)										ORGANISM SUSPECTED (If Applicable)									

## INSTRUCTIONS:

- Submit **each** specimen with a completed requisition.
- Information provided must include: Patient's name or a unique identifier, date of specimen collection, time of specimen collection, name & address of ordering physician (submitter), and the test to be performed. Additional information beyond the test requisition may be required dependent on the test requested. To avoid delays, complete the entire requisition as applicable.
- The **test requisition** and **specimen container** must have matching patient name/unique identifier and/or other relevant information or the specimen will not be tested. If the name/unique identifier on the specimen container differs from that on the test requisition, testing will not be performed.
- Every attempt will be made to salvage leaking or improperly submitted samples of cerebrospinal fluid, biopsy tissues, aspirates and other specimens attained by invasive procedures providing that the safety of the laboratory worker is not compromised.
- Serum/plasma specimens will be rejected if in glass tubes or other non-MDCH approved containers.

## ENTERIC CULTURE

Includes: *Salmonella*, *Shigella*, *Campylobacter*, and *E. coli* O157:H7.

## NEISSERIA CULTURE

Isolation and identification of *Neisseria gonorrhoeae* **only**.

## NOROVIRUS PCR

Norovirus testing must be approved by the MDCH Bureau of Epidemiology (517-335-8165) before stool specimens are submitted for testing.

## FOODBORNE DISEASE INVESTIGATION – ENTERIC CULTURES ONLY

This test requires prior approval and supporting epidemiological data. This testing is performed when two or more unrelated individuals are reported ill from a common source. Significant epidemiological data is required to perform this test.

Requests for this test **must** come through the local county health department. Food samples will be tested at the MDCH lab in Lansing.

This testing may include *Salmonella*, *Shigella*, *E. coli* O157:H7, and *Campylobacter*.

<sup>1</sup>All tests positive for *Chlamydia* will automatically be tested for *N. gonorrhoeae*.

### <sup>2</sup>Sexually Transmitted Diseases – Definitions

<b>Symptoms:</b>	Patient requesting examination due to symptoms, or, symptoms discovered on examination.
<b>Infected Partner:</b>	Patient has known exposure to STD (self-reported or documented).
<b>Partner Risk:</b>	Patient has multiple sex partners.
<b>History of STD:</b>	Patient has been diagnosed with a sexually transmitted disease within last 3 years.
<b>Prenatal Visit:</b>	Patient examination is part of prenatal visit.
<b>Age recommended:</b>	Recommended age criteria for screening female patients is $\leq 24$ for family planning clinics, adolescent and juvenile detention sites, and all ages for STD clinics.
<b>“Plan First!” Clients:</b>	A “Plan First!” client seeking family planning services will receive screening and teaching. As a Title X Standards & Guideline requirement, <i>Chlamydia trachomatis</i> and <i>Neisseria gonorrhoeae</i> screening must be offered to “Plan First!” clients < 24 years of age, prior to provision of a contraceptive method, if risk factors are reported.
<b>Retest:</b>	CDC recommends that women testing positive for <i>N. gonorrhoea</i> and <i>Chlamydia trachomatis</i> be retested approximately 3 months after treatment. Providers are also strongly encouraged to retest all women treated for these infections whenever they seek medical care within the following 3-12 months, regardless of whether the patient believes her sex partners were treated.