Multiple Patient/Sample - Same Test - Requisition

Bureau of Laboratories Michigan Department of Community Health

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Date Received at MDCH	ENTER STARLIMS CODE IF KNOWN							
Return Results to:	**Phone**							
	Fax							
	NATIONAL PROVIDER IDENTIFIER							

PATIENT/SAMPLE INFORMATION

MDCH SAMPLE NUMBER	**DATE COLLECTED**	SPECIMEN SOURCE	**PATIENT NAME/UNIQUE IDENTIFIER (OR SAMPLE TYPE)**	SUBMITTER PATIENT NUMBER	DATE OF BIRTH

SPECIMEN INFORMATION - INDICATE <u>ONE TEST</u> REQUESTED - <u>ONLY TESTS LISTED BELOW MAY BE ORDERED ON THIS REQUISITION</u>

☐ Foodborne Illness - Stool or Food ☐ Influenza

Other - (Must Have Prior Approval)_____

INDICATE TEST REASON BELOW

☐ Diagnosis ☐ Surveillance ☐ Suspected Outbreak - Specify: _____

☐ Other - Specify:_____

OUTBREAK IDENTIFIER (If Applicable)	ORGANISM SUSPECTED (If Applicable)