

Microbiology/Virology Test Requisition

Bureau of Laboratories Michigan Department of Community Health

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Technical Information 517-335-8067

Web: HTTP://www.Michigan.gov/mdchlab

Date Received at MDCH					MDCH Sample #															
AGENCY - SUBMITTER INFORMATION					ENTER STARLIMS AGENCY CODE															
Return Results to:		FP <input type="radio"/>	Phone (24/7)																	
		STD <input type="radio"/>	FAX																	
CONTACT PERSON/ REFERRING PHYSICIAN/ PROVIDER NAME					NATIONAL PROVIDER IDENTIFIER:															
PATIENT INFORMATION - NAME (LAST, FIRST, MIDDLE INITIAL OR UNIQUE IDENTIFIER) Must Match Specimen Label Exactly																				
SUBMITTER'S PATIENT #-IF APPLICABLE																				
PATIENT'S CITY-RESIDENCE										ZIP CODE			GENDER		<input type="radio"/> Female <input type="radio"/> Male					
RACE		<input type="radio"/> BLACK/AA <input type="radio"/> WHITE <input type="radio"/> NATIVE AMERICAN OR ALASKAN <input type="radio"/> ASIAN <input type="radio"/> HAWAIIAN/PI <input type="radio"/> UNKNOWN <input type="radio"/> OTHER (SPECIFY): _____																		
ETHNICITY		HISPANIC <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNKNOWN				DATE OF BIRTH		M	M	D	D	Y	Y	Y	Y					
		ARAB DESCENT <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNKNOWN																		
SUBSCRIBER INFORMATION <input type="radio"/> MEDICAID <input type="radio"/> PLAN FIRST! <input type="radio"/> ADAP <input type="radio"/> DOC <input type="radio"/> OTHER _____																				
SUBSCRIBER #																				
SUBMITTER'S SPECIMEN # - IF APPLICABLE																				
DATE COLLECTED		M	M	D	D	Y	Y	Y	Y	TIME COLLECTED					<input type="radio"/> A.M.		<input type="radio"/> P.M.			

INDICATE TEST REQUESTED (complete specimen source information on back)																			
SEROLOGY <input type="radio"/> ARBOVIRUS ENCEP. PANEL (IgM) § <input type="radio"/> BRUCELLA SEROLOGY <input type="radio"/> FUNGAL SEROLOGY COMPLEMENT FIXATION <input type="radio"/> FUNGAL IMMUNODIFFUSION <input type="radio"/> FRANCISELLA SEROLOGY <input type="radio"/> LEGIONELLA - HA <input type="radio"/> LYME DISEASE - EIA Complete # 4 (reverse) <input type="radio"/> MEASLES IgG <input type="radio"/> MUMPS IgG <input type="radio"/> RABIES AB SEROLOGY Complete # 3 (reverse) <input type="radio"/> RUBELLA IgG <input type="radio"/> TETANUS TOXIN EIA <input type="radio"/> VARICELLA ZOSTER IgG SERUM STATUS - If Applicable <input type="radio"/> Acute <input type="radio"/> Convalescent § May – October Includes Eastern Equine, California, St. Louis and West Nile. CSF only MISCELLANEOUS <input type="radio"/> AUTOCLAVE TEST STRIPS <input type="radio"/> LEGIONELLA - DFA <input type="radio"/> LYME DISEASE-IFA (Tick)					SYPHILIS TESTING <input type="radio"/> SYPHILIS (USR Test) <input type="radio"/> SYPHILIS VDRL - CSF Only <input type="radio"/> SYPHILIS DFA Complete # 2 (reverse) <input type="radio"/> SYPHILIS FTA - ABS DS* <input type="radio"/> SYPHILIS IgM WESTERN BLOT* <input type="radio"/> SYPHILIS TP-PA* (* Prior Approval Required) HIV TESTING <input type="radio"/> HIV AB – Serum <input type="radio"/> HIV AB - Oral Mucosal Transudate <input type="radio"/> CD4/CD8 (EDTA whole blood) <input type="radio"/> HIV-1 VIRAL LOAD (EDTA plasma) <input type="radio"/> HIV-1 GENOTYPING (EDTA plasma) HEPATITIS TESTING <input type="radio"/> HEPATITIS C SCREEN <input type="radio"/> HBsAg Complete #1 (reverse) <input type="radio"/> HEPATITIS B SURFACE AB (Anti-HBs) <input type="radio"/> HEPATITIS A VIRUS (IgM)					MICROBIOLOGY <input type="radio"/> AEROBIC ISOLATE ID Complete # 5 (Reverse) <input type="radio"/> AFB SUSCEPTIBILITY <input type="radio"/> AFB SLIDE/CULTURE-CLINICAL SPECIMEN <input type="radio"/> AFB Identification – Isolate ID <input type="radio"/> C. trachomatis (Non-culture) ¹ <input type="radio"/> E. coli (SLT) TOXIN & SEROLOGY <input type="radio"/> ENTERIC BACTERIAL CULTURE <input type="radio"/> FOODBORNE ILLNESS - Stool or Food Complete # 6 (Reverse) <input type="radio"/> FUNGAL IDENTIFICATION– Isolate ID <input type="radio"/> LEGIONELLA CULTURE <input type="radio"/> NEISSERIA GONORRHOEAE - Isolation <input type="radio"/> NEISSERIA - REFERRED CULTURE <input type="radio"/> PARASITOLOGY – BLOOD <input type="radio"/> PARASITOLOGY – Stool <input type="radio"/> PARASITOLOGY – WORM <input type="radio"/> PERTUSSIS PCR <input type="radio"/> Salmonella/Shigella SEROTYPING-Human					VIRAL CULTURE <input type="radio"/> ENTEROVIRUS CULTURE <input type="radio"/> VIRAL RESPIRATORY PANEL Tests That Require Prior MDCH Approval <input type="radio"/> BACTERIAL TYPING – PFGE Complete # 6 (Reverse) <input type="radio"/> BOTULISM TOXIN <input type="radio"/> ENTEROVIRUS - PCR <input type="radio"/> MUMPS - CULTURE <input type="radio"/> MUMPS - PCR <input type="radio"/> MEASLES IgM @ CDC <input type="radio"/> NOVEL INFLUENZA A - PCR <input type="radio"/> NOROVIRUS – PCR Complete # 6 (Reverse) <input type="radio"/> PERTUSSIS CULTURE <input type="radio"/> RUBELLA IgM <input type="radio"/> SALMONELLA SEROTYPING (Non-Human) <input type="radio"/> TOXIC SHOCK TESTING <input type="radio"/> Other: _____ <input type="radio"/> Other: _____				

INDICATE SPECIMEN SOURCE BELOW

<input type="checkbox"/> Bronchial	<input type="checkbox"/> Gastric	<input type="checkbox"/> Plasma	<input type="checkbox"/> Sputum	<input type="checkbox"/> Urine	<input type="checkbox"/> Whole Blood
<input type="checkbox"/> Cervix	<input type="checkbox"/> Nasopharyngeal	<input type="checkbox"/> Serum	<input type="checkbox"/> Throat	<input type="checkbox"/> Food - Specify:	
<input type="checkbox"/> CSF	<input type="checkbox"/> Oral Mucosal Transudate	<input type="checkbox"/> Stool	<input type="checkbox"/> Urethra	<input type="checkbox"/> Other - Specify:	

INDICATE TEST REASON BELOW

<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Surveillance	<input type="checkbox"/> Outbreak (complete Section 6)	<input type="checkbox"/> Other – Specify: _____
STD* <input type="checkbox"/> Symptoms <input type="checkbox"/> Prenatal Visit <input type="checkbox"/> Infected Partner <input type="checkbox"/> Partner Risk <input type="checkbox"/> History of STD (< 3years) <input type="checkbox"/> Age recommended for Testing <input type="checkbox"/> Retest			

1	IF REQUESTING EXAMINATION FOR: HEPATITIS B COMPLETE ALL THAT APPLY									
<input type="checkbox"/> Pregnancy (HBsAg)	<input type="checkbox"/> Exposure to someone with Hepatitis B									

2	IF REQUESTING EXAMINATION FOR: SYPHILIS - DFA COMPLETE THIS SECTION									
Duration of Lesion				<input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Years	Specify Site:					

3	IF REQUESTING EXAMINATION FOR: RABIES ANTIBODY SEROLOGY COMPLETE THIS SECTION										
Date of Last Rabies Vaccination	M	M	D	D	Y	Y	Y	Y			

4	IF REQUESTING EXAMINATION FOR: LYME BORRELIOSIS COMPLETE THIS SECTION										
ONSET DATE	M	M	D	D	Y	Y	Y	Y	State/County/Country of Exposure		
EARLY DISEASE	<input type="checkbox"/> Erythema migrans <input type="checkbox"/> Symptoms (Specify): _____ (5 cm at least in diameter) (Ex., Rash, Fever, Headache, Joint Pain)						LATE DISEASE	<input type="checkbox"/> Neurologic <input type="checkbox"/> Cardiac <input type="checkbox"/> Rheumatologic			

5	IF REQUESTING EXAMINATION FOR: AEROBIC CULTURE COMPLETE ALL THAT APPLY									
<input type="checkbox"/> Aerobe <input type="checkbox"/> Microaerophile Gram <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Variable <input type="checkbox"/> Rod <input type="checkbox"/> Coccus <input type="checkbox"/> Diplococcus Bacterial Growth Char.: MacConkey <input type="checkbox"/> Pos <input type="checkbox"/> Neg Oxidase <input type="checkbox"/> Pos <input type="checkbox"/> Neg Catalase <input type="checkbox"/> Pos <input type="checkbox"/> Neg Dextrose <input type="checkbox"/> Oxidation <input type="checkbox"/> Fermentation <input type="checkbox"/> Other: _____ _____ _____										

6	IF REQUESTING EXAMINATION FOR: OUTBREAK INVESTIGATION COMPLETE THIS SECTION										
ONSET DATE	M	M	D	D	Y	Y	Y	Y			
OUTBREAK IDENTIFIER (Foodborne ONLY - If Applicable)											
ORGANISM SUSPECTED (If Applicable)											
MDCH Prior Approval: Name, date or code											

***Sexually Transmitted Diseases – Definitions**

- Symptoms:** Patient requesting examination due to symptoms, or, symptoms discovered on examination.
- Infected Partner:** Patient has known exposure to STD (self-reported or documented).
- Partner Risk:** Patient has multiple sex partners.
- History of STD:** Patient has been diagnosed with a sexually transmitted disease within last 3 years.
- Prenatal Visit:** Patient examination is part of prenatal visit.
- Age recommended:** Recommended age criteria for screening female patients is ≤ 24 for family planning clinics, adolescent and juvenile detention sites, and all ages for STD clinics.
- “Plan First!” Clients:** A “Plan First!” client seeking family planning services will receive screening and teaching. As a Title X Standards & Guideline requirement, *Chlamydia trachomatis* and *Neisseria gonorrhoeae* screening must be offered to “Plan First!” clients < 24 years of age, prior to provision of a contraceptive method, if risk factors are reported. CDC recommends that women testing positive for *N. gonorrhoea* and *Chlamydia trachomatis* 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.
- Retest:**

¹All tests positive for *Chlamydia* will automatically be tested for *N. gonorrhoeae*.