

**Quick Guide** to filling out the MDCH (Michigan Department of Community Health)  
Laboratory Test Requisition for Influenza Testing

**Important:** To run the test without delays, we must have **both of the following:**

1. This laboratory requisition form (see next page) with complete and correct information.
  - *The information on this form must match the specimen tube exactly*
  - *For example, if the patient's name is "Daniel" do not write "Dan" on the tube and Daniel" on the requisition.*
  - *For CLIA requirements and patient safety, we cannot make changes to the identifying information when testing has been completed.*
  - *Other agencies such as your local health department may require additional forms for approval, patient history, or for other public health purposes. However, these other forms cannot be used as a substitute for this requisition when sending tests to the Michigan Department of Community Health laboratory in Lansing.*

**AND**

2. The specimen correctly labeled with:
  - patient name or other unique identifier
  - patient date of birth
  - date and time of specimen collection

**Please double check the information on the specimen and the laboratory requisition form before you send them to us for testing.**

**Download a copy of the MDCH Laboratory Test Requisition form at**  
[http://www.michigan.gov/documents/DCH-0583TEST\\_REQUEST\\_7587\\_7.pdf](http://www.michigan.gov/documents/DCH-0583TEST_REQUEST_7587_7.pdf)

**Turn to Page 2 for step-by-step directions on how to fill out the form.**



Check for updates on our MDCH laboratory web page at  
<http://www.michigan.gov/mdchlab>

View the current testing algorithm at  
[http://www.michigan.gov/documents/mdch/2010\\_Influenza\\_Algorithm\\_20101004\\_334559\\_7.pdf](http://www.michigan.gov/documents/mdch/2010_Influenza_Algorithm_20101004_334559_7.pdf)

**Boxes 1 - 4** Enter Your information (*You are the submitter*)

**Boxes 5 - 9** Enter Patient Information

**Boxes 10 - 13** Enter Specimen Information

**1. Name of Facility / Office and Mailing address**  
(*This is where we will send the lab report*)

**2. Facility Telephone**

**3. Facility Fax**

**4. Name of a Person\***

(\* From your office or facility, in case we have questions)

**5. Patient's Name (Last, First, M.I.)** OR another unique identifier. *If using an identifier other than patient name, be sure to keep a record so that you can match the results to the patient later.*

**6. City where the Patient lives** (we send a copy of our results to the local health department)

**7. Patient's Gender** indicate M or F

**8. Patient's Date of Birth** (MMDDYYYY)

**9. Race/Ethnicity** (if known)

**10. Date and Time specimen was collected**

**11. Test Requested**  
Check "other" box, write in "Influenza"

**On page 2:**  
**12. Specimen Source:**  
Check appropriate box, usually: Nasopharyngeal

**13. Reason for Testing**  
*ICU, pregnant & severely ill, patient with unusual & severe presentation, death, outbreak investigation by local health dept – enter under "other – specify"*

**Microbiology/Virology Test Requisition**  
**Bureau of Laboratories Michigan Department of Community Health**

PO Box 30035 3350 North Martin Luther King Jr. Blvd. Lansing Michigan 48909

Laboratory Records: 517-335-8039 Fax: 517-335-9871 Technical Information: 517-335-8067 Web: HTTP://www.Michigan.gov/mdchlab

Date Received at MDCH		MEDCH Sample #	
AGENCY - SUBMITTER INFORMATION		ENTER STARLIMS AGENCY CODE	
Return Results to:	1	Phone (24/7)	2
	FF		
	STD	FAX	3
CONTACT PERSON/ REFERRING PHYSICIAN/ PROVIDER NAME		NATIONAL PROVIDER IDENTIFIER:	
4			
PATIENT INFORMATION - NAME (LAST, FIRST, MIDDLE INITIAL OR UNIQUE IDENTIFIER) Must Match Specimen Label Exactly			
5			
SUBMITTER'S PATIENT # - IF APPLICABLE			
PATIENT'S CITY-RESIDENCE		ZIP CODE	GENDER 7
6			Female <input type="radio"/>
RACE	9		
<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	DATE OF BIRTH	8
	ARAB DESCENT		
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	TIME COLLECTED		10
10			<input type="radio"/> A.M.

<b>SEROLOGY</b> <input type="radio"/> ARBOVIRUS ENCEP. PANEL (IgM) § <input type="radio"/> BRUCELLA SEROLOGY <input type="radio"/> FUNGAL SEROLOGY <input type="radio"/> COMPLEMENT FIXATION <input type="radio"/> FUNGAL IMMUNODIFFUSION <input type="radio"/> FRANCISELLA SEROLOGY <input type="radio"/> LEGIONELLA - HA <input type="radio"/> LYME DISEASE - EIA <input type="radio"/> MEASLES IgG <input type="radio"/> MUMPS IgG <input type="radio"/> RABIES AB SEROLOGY <input type="radio"/> RUBELLA IgG <input type="radio"/> TETANUS TOXIN EIA <input type="radio"/> VARICELLA ZOSTER. IgG <b>SERUM STATUS - If Applicable</b> <input type="radio"/> Acute <input type="radio"/> Convalescent § May - October Includes Eastern Equine, California, St. Louis and West Nile. CSF only <b>MISCELLANEOUS</b> <input type="radio"/> AUTOCLAVE TEST STRIPS <input type="radio"/> LEGIONELLA - DFA <input type="radio"/> LYME DISEASE-IFA (Tick)	<b>SYPHILIS TESTING</b> <input type="radio"/> SYPHILIS (USR Test) <input type="radio"/> SYPHILIS VDRL - CSF Only <input type="radio"/> SYPHILIS DFA <input type="radio"/> 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) <b>HIV TESTING</b> <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) <b>HEPATITIS TESTING</b> <input type="radio"/> HEPATITIS C SCREEN <input type="radio"/> HBsAg Complete #1 (reverse) <input type="radio"/> HEPATITIS B SURFACE AB (Anti-HBc) <input type="radio"/> HEPATITIS A VIRUS (IgM)	<b>MICROBIOLOGY</b> <input type="radio"/> AEROBIC ISOLATE ID <input type="radio"/> 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) <sup>1</sup> <input type="radio"/> E. coli (SLT) TOXIN & SEROLOGY <input type="radio"/> ENTERIC BACTERIAL CULTURE <input type="radio"/> FOODBORNE ILLNESS - Stool or Food <input type="radio"/> 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	<b>VIRAL CULTURE</b> <input type="radio"/> ENTEROVIRUS CULTURE <input type="radio"/> VIRAL RESPIRATORY PANEL <b>Tests That Require Prior MDCH Approval</b> <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 <input type="radio"/> Complete # 6 (Reverse) <input type="radio"/> PERTUSSIS CULTURE <input type="radio"/> RUBELLA IgM <input type="radio"/> SALLMONELLA SEROTYPING (Non-Human) <input type="radio"/> TOXIC SHOCK TESTING <input type="radio"/> Other: <b>11</b> <b>influenza</b>
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Instructions for completion: Completely fill in the appropriate circle. For example, upon completion the circle should appear as , rather than .  
DCH-0583 (Reverse) July 7, 2011 By Authority of Act 368, P.A. 1978

**INDICATE SPECIMEN SOURCE BELOW** 12

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

**INDICATE TEST REASON BELOW**

<input type="radio"/> Diagnosis	<input type="radio"/> Surveillance	<input type="radio"/> Outbreak (complete Section 6)	<input type="radio"/> Other - Specify: 13
STD* <input type="radio"/> Symptoms <input type="radio"/> Prenatal Visit <input type="radio"/> Infected Partner <input type="radio"/> Partner Risk <input type="radio"/> History of STD (< 3years) <input type="radio"/> Age recommended for Testing			