

STATE OF MICHIGAN - LABORATORY TEST REQUISITION

Microbiology / Virology

DATE RECEIVED IN LABORATORY	LABORATORY SAMPLE NUMBER
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Michigan Department of Health and Human Services - Bureau of Laboratories
 P.O. Box 30035 3350 North Martin Luther King Jr. Blvd. Lansing, MI 48909
 Laboratory Records: 517-335-8059 Technical Information: 517-335-8067
 Fax: 517-335-9871 Web: www.michigan.gov/mdhhs/ab

SUBMITTER INFORMATION

SUBMITTER INFORMATION (PRINTED, TYPED OR STAMPED)	<input type="checkbox"/> FP	AGENCY CODE (If Known) <table border="1" style="width:100%; height: 20px;"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table>																				
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PATIENT INFORMATION

NAME (LAST, FIRST, MIDDLE INITIAL) or UNIQUE IDENTIFIER <table border="1" style="width:100%; height: 20px;"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table>																																										
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ETHNICITY <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	ADAP NUMBER <table border="1" style="width:100%; height: 20px;"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table>																																									
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INDICATE TEST REQUESTED

INSTRUCTIONS FOR COMPLETION: Complete reverse side of form for corresponding numbers in parentheses and in bold.

<p>INDICATE SPECIMEN SOURCE</p> <p><input type="checkbox"/> AMNIOTIC FLUID</p> <p><input type="checkbox"/> BRONCHIAL</p> <p><input type="checkbox"/> CERVIX</p> <p><input type="checkbox"/> CSF</p> <p><input type="checkbox"/> GASTRIC</p> <p><input type="checkbox"/> NASOPHARYNGEAL</p> <p><input type="checkbox"/> ORAL MUCOSAL TRANSUDATE</p> <p><input type="checkbox"/> PLASMA</p> <p><input type="checkbox"/> SERUM</p> <p><input type="checkbox"/> STOOL</p> <p><input type="checkbox"/> SPUTUM</p> <p><input type="checkbox"/> THROAT</p> <p><input type="checkbox"/> URETHRA</p> <p><input type="checkbox"/> URINE</p> <p><input type="checkbox"/> WHOLE BLOOD</p> <p><input type="checkbox"/> FOOD-Specify:</p> <p><input type="checkbox"/> OTHER-Specify:</p>	<p>SEROLOGY</p> <p>SERUM STATUS - If Applicable</p> <p><input type="checkbox"/> ACUTE <input type="checkbox"/> CONVALESCENT</p> <p><input type="checkbox"/> ARBOVIRUS ENCEP PANEL (IgM) May-Oct Includes: Eastern Equine, California, St. Louis and West Nile CSF Only</p> <p><input type="checkbox"/> BRUCELLA SEROLOGY</p> <p><input type="checkbox"/> FUNGAL SEROLOGY COMPLEMENT FIX</p> <p><input type="checkbox"/> FUNGAL IMMUNODIFFUSION</p> <p><input type="checkbox"/> FRANCISELLA SEROLOGY</p> <p><input type="checkbox"/> LEGIONELLA - HA</p> <p><input type="checkbox"/> LYME DISEASE - EIA (4)</p> <p><input type="checkbox"/> MEASLES IgG</p> <p><input type="checkbox"/> MUMPS IgG</p> <p><input type="checkbox"/> RABIES AB SEROLOGY (3)</p> <p><input type="checkbox"/> RUBELLA IgG</p> <p><input type="checkbox"/> TETANUS TOXIN EIA</p> <p><input type="checkbox"/> VARICELLA ZOSTER IgG</p>	<p>MICROBIOLOGY</p> <p><input type="checkbox"/> AEROBIC ISOLATE ID (5)</p> <p><input type="checkbox"/> ANTIMICROBIAL RESISTANCE CONF. (5)</p> <p><input type="checkbox"/> AFB SLIDE/CULTURE-CLINICAL SPECIMEN</p> <p><input type="checkbox"/> AFB IDENTIFICATION-ISOLATE ID</p> <p><input type="checkbox"/> ENTERIC BACTERIAL CULTURE</p> <p><input type="checkbox"/> FOODBORNE ILLNESS-Stool or Food (6)</p> <p><input type="checkbox"/> FUNGAL IDENTIFICATION - ISOLATE ID</p> <p><input type="checkbox"/> LEGIONELLA CULTURE</p> <p><input type="checkbox"/> NEISSERIA GONORRHOEAE - ISOLATION</p> <p><input type="checkbox"/> NEISSERIA - REFERRED CULTURE</p> <p><input type="checkbox"/> PARASITOLOGY - BLOOD</p> <p><input type="checkbox"/> PARASITOLOGY - STOOL</p> <p><input type="checkbox"/> PARASITOLOGY - WORM</p> <p><input type="checkbox"/> PERTUSSIS PCR</p> <p><input type="checkbox"/> SALMONELLA SEROTYPING - HUMAN</p> <p><input type="checkbox"/> SHIGELLA SEROTYPING</p> <p><input type="checkbox"/> E. COLI SHIGA-TOXIN PRODUCER (STEC)</p>	<p>TESTS THAT REQUIRE MDHHS APPROVAL</p> <p>EMERGING ARBOVIRUS PANEL</p> <p><input type="checkbox"/> PCR <input type="checkbox"/> SEROLOGY</p> <p><input type="checkbox"/> AFB NUCLEIC ACID AMPLIFICATION</p> <p><input type="checkbox"/> BACTERIAL TYPING-PFGE (6)</p> <p><input type="checkbox"/> BOTULISM TOXIN</p> <p><input type="checkbox"/> MUMPS - PCR</p> <p><input type="checkbox"/> MEASLES IgM</p> <p><input type="checkbox"/> NOROVIRUS PCR (6)</p> <p><input type="checkbox"/> PERTUSSIS CULTURE</p> <p><input type="checkbox"/> RUBELLA IgM (1)</p> <p><input type="checkbox"/> SALMONELLA SEROTYPING NON-HUMAN</p> <p><input type="checkbox"/> TOXIC SHOCK TESTING</p> <p><input type="checkbox"/> OTHER _____</p>
<p>HIV TESTING</p> <p><input type="checkbox"/> HIV Ag/Ab - Serum (1)</p> <p><input type="checkbox"/> HIV Ag/Ab-Oral Mucosal Transudate (1)</p> <p><input type="checkbox"/> CD4/CD8 (EDTA whole blood) (1)</p> <p><input type="checkbox"/> HIV-1 VIRAL LOAD (EDTA plasma) (1)</p> <p><input type="checkbox"/> HIV-1 GENOTYPING (EDTA plasma) (1)</p>	<p>SYPHILIS TESTING</p> <p><input type="checkbox"/> SYPHILIS PANEL (1)</p> <p><input type="checkbox"/> SYPHILIS TP-PA (ONLY) (1)</p> <p><input type="checkbox"/> SYPHILIS VDRL - CSF Only (1)</p> <p><input type="checkbox"/> SYPHILIS DFA (1,2)</p> <p><input type="checkbox"/> SYPHILIS IgM WESTERN BLOT* (1)</p>	<p>VIROLOGY</p> <p><input type="checkbox"/> ENTEROVIRUS PCR (6)</p> <p><input type="checkbox"/> RESPIRATORY PCR PANEL</p> <p><input type="checkbox"/> INFLUENZA (PCR/CULTURE) (7)</p> <p>PATIENT STATUS (Influenza)</p> <p><input type="checkbox"/> OUTPATIENT <input type="checkbox"/> INPATIENT</p> <p><input type="checkbox"/> UNKNOWN</p> <p><input type="checkbox"/> VIRAL CULTURE</p>	<p>OTHER</p> <p><input type="checkbox"/> AUTOCLAVE TEST STRIPS</p> <p><input type="checkbox"/> LEGIONELLA - DFA</p> <p><input type="checkbox"/> LYME DISEASE - DFA (Tick)</p>
<p>HEPATITIS TESTING</p> <p><input type="checkbox"/> HEPATITIS C ANTIBODY (1)</p> <p><input type="checkbox"/> HEPATITIS B SURFACE ANTIGEN (HBsAg) (1)</p> <p><input type="checkbox"/> HEPATITIS B ANTIBODY (Anti-HBsAg) (1)</p> <p><input type="checkbox"/> HEPATITIS A ANTIBODY (IgM) (1)</p>			

Microbiology / Virology

INDICATE TEST REASON

 Diagnosis Surveillance Outbreak (Complete Section 6) Other (Specify) _____
(1) COMPLETE THIS SECTION FOR: HIV, SYPHILIS, HEPATITIS, RUBELLA IgM REQUESTS

PREGNANT?

 YES NO

FOR HEPATITIS B SURFACE ANTIGEN (HBsAg) ONLY

 Exposure to someone with Hepatitis B?
(2) COMPLETE THIS SECTION FOR: SYPHILIS DFA REQUESTS

DURATION OF LESION

 Days Months Years

SPECIFIC SITE: _____

(3) COMPLETE THIS SECTION FOR: RABIES ANTIBODY SEROLOGY REQUESTS

DATE OF LAST RABIES VACCINATION

DATE (MM-DD-YY)

(4) COMPLETE THIS SECTION FOR: LYME BORRELIOSIS REQUESTS

ONSET DATE (MM-DD-YY)

State/County/Country of

Exposure: _____

EARLY DISEASE

 Erythema Migrans (5 cm at least in diameter)

 Symptoms (Example- Rash, Fever, Headache, Joint Pain)

LATE DISEASE

 Neurologic Cardiac Rheumatologic
(5) COMPLETE THIS SECTION FOR: AEROBIC CULTURE REQUESTS AND ANTIMICROBIAL RESISTANCE CONFIRMATION*
 Aerobe Microaerophile

GRAM

 Positive Negative Variable

 Rod Coccus Diplococcus

BACTERIAL GROWTH CHARACTERISTICS:

MacConkey

 Positive Negative

Oxidase

 Positive Negative

Catalase

 Positive Negative

Dextrose

 Oxidation Fermentation

* SUBMIT COPY OF ANTIMICROBIAL SUSCEPTIBILITY TEST RESULTS

OTHER: _____

(6) COMPLETE THIS SECTION FOR: OUTBREAK INVESTIGATION

ONSET DATE (MM-DD-YY)

OUTBREAK IDENTIFIER

ORGANISM SUSPECTED (If Applicable)

MDHHS PRIOR APPROVAL: Name, Date _____

(7) COMPLETE THIS SECTION FOR: INFLUENZA TESTING (PCR / CULTURE) REQUESTS

LAST INFLUENZA VACCINATION:

DATE (MM-DD-YY)

TYPE

 Flu Mist Trivalent (Shot) Other _____
(8) ADDITIONAL INFORMATION

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

By Authority of Act 368, P.A. 1978