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

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

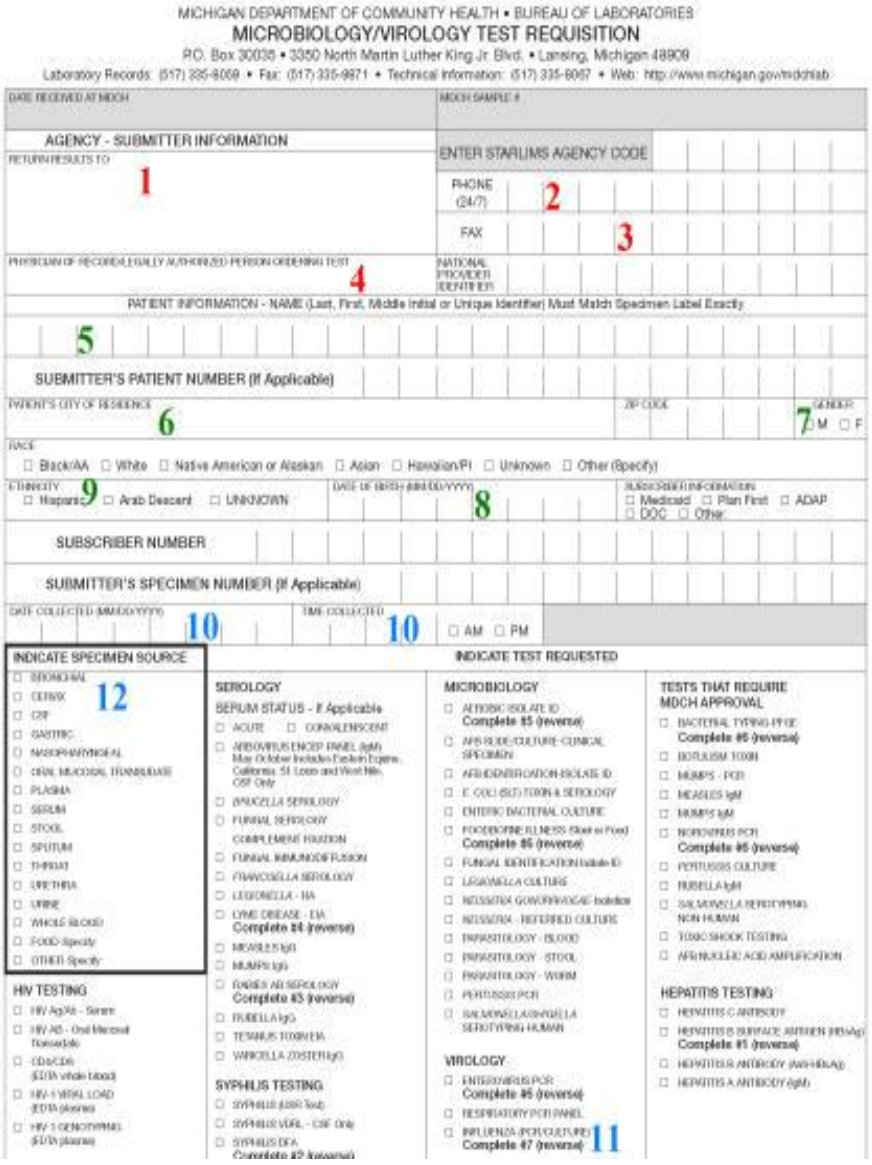
Check for updates on our MDCH laboratory web page at
http://www.michigan.gov/mdchlab

View the current testing algorithm at
http://www.michigan.gov/documents/mdch/2010_Influenza_Algorithm_20101004_334559_7.pdf

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

Boxes 5 - 9 Enter **Patient** Information

Boxes 10 - 13 Enter **Specimen** Information



MICHIGAN DEPARTMENT OF COMMUNITY HEALTH • BUREAU OF LABORATORIES

MICROBIOLOGY/VIROLOGY TEST REQUISITION

P.O. Box 30035 • 3350 North Martin Luther King Jr. Blvd. • Lansing, Michigan 48909

Laboratory Records: (517) 335-8059 • Fax: (517) 335-9871 • 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 1 | PHONE (24/7) 2 | FAX 3

PHYSICIAN OF RECORD/LEGALLY AUTHORIZED PERSON ORDERING TEST 4 | NATIONAL PROVIDER IDENTIFIER

PATIENT INFORMATION - NAME (Last, First, Middle Initial or Unique Identifier) Must Match Specimen Label Exactly

5

SUBMITTER'S PATIENT NUMBER (If Applicable)

PATIENT'S CITY OF RESIDENCE 6 | ZIP CODE | GENDER 7 M F

RACE ☐ Black/AA ☐ White ☐ Native American or Alaskan ☐ Asian ☐ Hawaiian/PI ☐ Unknown ☐ Other (Specify)

ETHNICITY 9 ☐ Hispanic ☐ Arab Descent ☐ UNKNOWN | DATE OF BIRTH (MM/DD/YYYY) 8 | SUBSCRIBER INFORMATION ☐ Medicaid ☐ Plan First ☐ ADAP ☐ DOC ☐ Other

SUBSCRIBER NUMBER

SUBMITTER'S SPECIMEN NUMBER (If Applicable)

DATE COLLECTED (MM/DD/YYYY) 10 | TIME COLLECTED 10 ☐ AM ☐ PM

INDICATE SPECIMEN SOURCE 12

☐ BRONCHIAL
☐ CERVIX
☐ CSF
☐ GASTRIC
☐ NASOPHARYNGEAL
☐ ORAL MUCOSAL TRANSUDATE
☐ PLASMA
☐ SERUM
☐ STOOL
☐ SPUTUM
☐ THROAT
☐ URETHRA
☐ URINE
☐ WHOLE BLOOD
☐ Food- Specify
☐ OTHER- Specify

HIV TESTING
☐ HIV Ag/Ab - Serum
☐ HIV Ab - Oral Mucosal Transudate
☐ CD4/CD8 (EDTA whole blood)
☐ HIV-1 VIRAL LOAD (EDTA plasma)
☐ HIV-1 GENOTYPING (EDTA plasma)

INDICATE TEST REQUESTED

SEROLOGY
SERUM STATUS - If Applicable ☐ ACUTE ☐ CONVALESCENT
☐ ARBOVIRUS ENCEP. PANEL (IgM) May Include Eastern Equine, California, St. Louis and West Nile. CSF Only
☐ BRUCELLA SEROLOGY
☐ FUNGAL SEROLOGY
COMPLEMENT FIXATION
☐ FUNGAL IMMUNODIFFUSION
☐ FRANCISELLA SEROLOGY
☐ LEGIONELLA - IFA
☐ LYME DISEASE - EIA Complete #4 (reverse)
☐ MEASLES IgG
☐ MUMPS IgG
☐ RABIES AB SEROLOGY Complete #3 (reverse)
☐ RUBELLA IgG
☐ TETANUS TOXOID EIA
☐ VARICELLA ZOSTER IgG

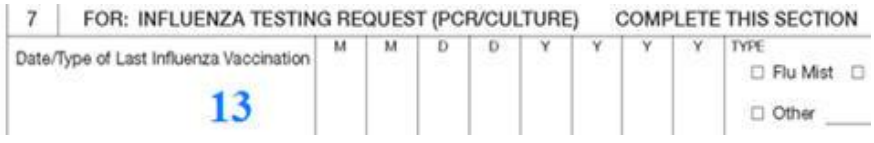
SYPHILIS TESTING
☐ SYPHILIS (USR Test)
☐ SYPHILIS VDRL - CSF Only
☐ SYPHILIS EIA Complete #2 (reverse)

MICROBIOLOGY
☐ AEROBIC ISOLATE ID Complete #5 (reverse)
☐ AFB SLIDE CULTURE-CLINICAL SPECIMEN
☐ AFB IDENTIFICATION-ISOLATE ID
☐ E. COLI (SLT) TOXIN & SEROLOGY
☐ ENTERIC BACTERIAL CULTURE
☐ FOODBORNE ILLNESS (Stool or Food) Complete #6 (reverse)
☐ FUNGAL IDENTIFICATION Isolate ID
☐ LEGIONELLA CULTURE
☐ NEISSERIA GONORRHOEAE Isolation
☐ NEISSERIA - REFERRED CULTURE
☐ PARASITOLOGY - BLOOD
☐ PARASITOLOGY - STOOL
☐ PARASITOLOGY - WORM
☐ PERTUSSIS PCR
☐ SALMONELLA/SHIGELLA SEROTYPING HUMAN

VIROLOGY
☐ ENTEROVIRUS PCR Complete #6 (reverse)
☐ RESPIRATORY PCR PANEL
☐ INFLUENZA (PCR/CULTURE) Complete #7 (reverse) 11

TESTS THAT REQUIRE MDCH APPROVAL
☐ BACTERIAL TYPING PFGE Complete #5 (reverse)
☐ BOTULISM TOXIN
☐ MUMPS - PCR
☐ MEASLES IgM
☐ MUMPS IgM
☐ NOROVIRUS PCR Complete #5 (reverse)
☐ PERTUSSIS CULTURE
☐ RUBELLA IgM
☐ SALMONELLA SEROTYPING NON HUMAN
☐ TOXIC SHOCK TESTING
☐ AFB NUCLEIC ACID AMPLIFICATION

HEPATITIS TESTING
☐ HEPATITIS C ANTIBODY
☐ HEPATITIS B SURFACE ANTIGEN (HBsAg) Complete #1 (reverse)
☐ HEPATITIS B ANTIBODY (Anti-HBsAg)
☐ HEPATITIS A ANTIBODY (IgM)



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

Date/Type of Last Influenza Vaccination 13 | M M D D Y Y Y Y | TYPE ☐ Flu Mist ☐ Other ____

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 Influenza(PCR/Culture)

12. Enter specimen source

On page 2

13. Complete #7 Date & Type of Last Influenza Vaccination