INFECTIOUS DISEASE TEST REQUEST FORM

UTAH PUBLIC HEALTH LABORATORY

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http://health.utah.gov/lab/infectious-diseases

FOR UPHL USE ONLY

LAB#

DATE STAMP

PLEASE PRINT CLEARLY AND FILL OUT AS COMPLETELY AS POSSIBLE.

PATIENT INFORMATION:

PATIENT STATE OF RESIDENCE	PATIENT COUNTY OF RESIDENCE	ZIP CODE	DATE OF BIRTH (mm/dd/yyyy)	AGE	SEX
			_____/_____/_____		M F

LAST NAME	FIRST NAME	Is Patient Insured? [ ] Yes [ ] No If Yes, will insurance be billed? [ ] Yes [ ] No	**STI TESTING ONLY:** Is patient MSM? [ ] Yes [ ] No

PATIENT ID #	ETHNICITY	RACE
	[ ] Hispanic [ ] Non-Hispanic	[ ] White [ ] Black or African American [ ] American Indian or Alaska Native [ ] Asian [ ] Native Hawaiian or other Pacific Islander

PROVIDER INFORMATION
Provider Code:

Physician: _____
Provider Phone: _____
Provider Email: _____
Secure Fax #: _____

SPECIMEN COLLECTION DATE AND TIME
(mm/dd/yy) _____/_____/_____
Time: _____

SPECIMEN SOURCE/SITE (CHOOSE 1)**:**

[ ] Blood	[ ] (Endo)tracheal aspirate/wash	[ ] Plasma	[ ] Tissue (specify):_____
[ ] Body Fluid (specify):_____	[ ] Environmental (specify):_____	[ ] Rectum	[ ] Urethra
[ ] Bronchoalveolar lavage	[ ] Food (specify):_____	[ ] Serum	[ ] Urine
[ ] Bronchial aspirate/wash	[ ] Lesion (site):_____	[ ] Sputum (natural / induced)	[ ] Vagina
[ ] Cerebrospinal Fluid	[ ] Nasal (aspirate /swab / wash)	[ ] Stool	[ ] Wound/Abscess
[ ] Cervix	[ ] Nasopharyngeal swab	[ ] Throat swab	[ ] Other (specify): _____

BIOTERRORISM TESTS (Notify lab before submitting)

[ ] Isolate [ ] Original Material

[ ] Bacillus anthracis (Detection/ID)
[ ] Brucella species (Detection/ID)
[ ] Brucella antibody
[ ] Burkholderia mallei/pseudomallei (Detection/ID)
[ ] Clostridium botulinum culture & toxin
[ ] Coxiella burnetii (Detection)
[ ] Ebola virus (Detection)
[ ] Francisella tularensis (Detection/Identification)
[ ] F. tularensis antibody
[ ] MERS CoV
[ ] Orthopox viruses Detection
Virus Suspected:_____
[ ] Rickettsia (Detection)
[ ] Yersinia pestis (Detection/Identification)
[ ] Yersinia pestis antibody
[ ] Other (specify): _____

BACTERIOLOGY/TUBERCULOSIS TESTS

[ ] Isolate [ ] Original Material

[ ] Salmonella [ ] Shigella
[ ] E. coli O157 [ ] EHEC/STEC
[ ] Campylobacter [ ] Haemophilus Influenzae
[ ] Neisseria gonorrhea [ ] Neisseria meningitidis
[ ] OME Culture [ ] CRE/CRPA/CRAB
[ ] Vibrio/Plesiomonas/Aeromonas
[ ] Other (specify):_____

Tuberculosis Specimen
[ ] GeneXpert
[ ] Mycobacterial culture
Has patient received chest x-ray? [ ] Yes [ ] No
If YES, did patient show signs of cavitary disease?
[ ] Yes [ ] No
[ ] Mycobacterial referral
Presumptive ID:_____
[ ] Other (specify): _____

IMMUNOLOGY TESTS

[ ] QuantiFERON-TB Gold
REQUIRED information:
Blood draw date/time:_____
Incubation at 37°C completed? [ ] Yes [ ] No
Signature:_____
Incubation start date/time:_____
Incubation end date/time:_____

[ ] Syphilis IgG EIA (includes confirmatory testing)
[ ] Suspect acute infection/previous positive

[ ] HIV Antigen/Antibody (includes confirmatory testing)
[ ] Previous positive

[ ] Hepatitis C Antibody
[ ] HCV RNA Testing if Positive

[ ] Hepatitis B Antibody

[ ] Hepatitis B Antigen (includes confirmatory testing)

[ ] Hantavirus (Sin Nombre) IgG/IgM
[ ] Acute Serum (mm/dd/yy)_____/_____/_____
[ ] Convalescent serum (mm/dd/yy)_____/_____/_____

[ ] West Nile virus IgM (Human)

[ ] Zika virus IgM

ADDITIONAL INFORMATION

[ ] Other Disease Suspected: _____

[ ] Referral Test (additional form(s) **REQUIRED**)
***Contact UPHL for additional form(s)**

VIROLOGY TESTS

Aptima NAAT
[ ] C. trachomatis and N. gonorrhea by NAAT
[ ] Patient is partner of a 15-24 year old female

Virus Identification
[ ] Respiratory Panel (FilmArray)
[ ] Herpes Simplex/Varicella zoster PCR
(HSV-1, HSV-2, VZV)
[ ] Trioplex PCR (Zika, Dengue, Chikungunya Viruses)

Influenza PCR
[ ] Influenza A & B virus PCR (with subtyping/genotyping)

COMMENTS: