COMMONWEALTH OF VIRGINIA – DEPARTMENT OF GENERAL SERVICES

Division of Consolidated Laboratory Services

600 N 5th St. Richmond, Va. 23219

Clinical Microbiology/Virology Request Form

Patient Information (Please Print)

Name _____ DOB _____/____/_____ Age_____ ○M ○F
Last First Middle Initial (mm dd yyyy)

Pt Address_____ City_____, State_____ Zip Code _____

City/County of Residence_____

Medical Record/Chart/Accession#_____ Patient ID_____

Marital Status: ○ single ○ married ○ separated ○ divorced ○ widowed ○ unknown

Race: ○ Black ○ White ○ Asian ○ AI/AN ○NH/PI ○ Other _____ **Ethnicity:** ○ Hispanic/Latino ○ Not-Hispanic/Latino
(check all that apply)

Submitter Information

Submitter Code # _____ Site code_____ FIPS code_____

Send Report to:

Submitter _____ Submitter Phone #_____-_____-_____
(Name of Health Dept, Hospital &/or private Clinician)

Submitter Address_____ City _____, State _____ Zip code_____

Attending Clinician_____

Attending Clinician Phone # _____-_____-_____

District or PH Contact_____

District or PH Contact Phone # _____-_____-_____

Site Type

○ STD	○ ATS	○ DCJ	○FP	○ GYN	○ Priv Phys
○ OB/prenatal care	○ AHC	○ Field	○ IMM	○ Job Corp	○ Peds
○ TB	○ GMC	○ CHC	○ DTC	○ Refugee	○ SOI
○ Hospital	○ OCME	○ Student HC	○ Other _____		

Patient Medical History

Disease suspected/Diagnosed _____

Signs/Symptoms

□ Asymptomatic □ Fever □ Respiratory □ Bloody sputum

□ Cough □ Productive cough □ Rash □ Vomiting

□ Diarrhea □ Stool + Blood □ Stool + Mucous □ Abdominal Pain

□ Apnea □ SIDS □ Sudden Unexplained Death

□ Other_____

Recent Exposure (if applicable) □ Birds □ Ticks □ Mosquitoes

□ Other _____

Date of Onset: _____/_____/_____ (mm dd yyyy)

Deceased Date: _____/_____/_____ (mm dd yyyy)

Vaccine Administered_____
(Please specify)
Vaccine Administration Date_____/_____/_____ (mm dd yyyy)

Antibiotics/Anti-Viral Used _____
(Please specify)
Antibiotics/Antiviral Start Date _____/_____/_____ (mm dd yyyy)

Special Information for Laboratorians

Outbreak Related □ no □ yes Outbreak Number: _____

Role of Patient (ex. food-handler, patron):_____

□ Other Information_____

***Complete information on back**

COMMONWEALTH OF VIRGINIA – DEPARTMENT OF GENERAL SERVICES
DIVISION OF CONSOLIDATED LABORATORY SERVICES

Clinical Microbiology/Virology Request Form

Test Request: **Patient Name/Identifier**_____ **Date of Birth** ____ /___ /_____

Enteric Screen/ Enteric Pathogens

Date Specimen Collected ____/____/_____
mm dd yyyy

Stool preserved in Cary-Blair Transport (Ship Room Temp)
□ Salmonella/Shigella/E. coli 0157/Campylobacter
□ Shiga Toxin □ Yersinia □ Vibrio
□ Other_____

Unpreserved Stool (Ship Cold Pack)
□ Norovirus
□ Other_____

Follow-up specimen? □ yes □ no If yes, what organism_____

Parasites: Intestinal and Blood-borne

Date(s) Collected (1) ___/_____/_____; (2) ___/_____/_____
mm dd yyyy mm dd yyyy

□ Ova and Parasite □ Pinworm
□ Cyclospora □ Blood Parasites
□ Giardia/Cryptosporidium FA
□ Other_____

Submitted in: (Room Temp)
□ 10% Formalin □ PVA □ EDTA Blood
□ Smears/slides □ Other_____

Unpreserved Stool (Cold Pack) Upon Request
□ Cyclospora □ Other_____
□ Cryptosporidium

□ Refugee Country visited outside US_____

Pertussis

Date Specimen Collected ____/____/_____
mm dd yyyy

B. pertussis: □ Culture □ PCR B. parapertussis: □ Culture
□ Other_____

Source:
□ Nasopharyngeal Swabs (Right and Left Nares)
□ Other_____

Clinical / Specimen Culture (Including OCME): □ Bacterial □ Fungal □ Viral □ Toxin

Date Specimen Collected ____/____/_____
mm dd yyyy

Source: □ Blood □ Urine □ Sputum □ Stool □ Swab (site) _____ □ Wound/Lesion (Site)_____ □ Respiratory _____

□ Tissue (type) _____ □ Body Fluid (type)_____ □ Other _____

Organism/Toxin Suspected: _____**Submitted on** (type media) _____

Reference Culture / Isolate: □ Bacterial □ Enteric □ Fungal □ Viral □ PFGE

Date Specimen Collected ____/____/_____
mm dd yyyy

Test Requested: _____

Source: □ Blood □ CSF □ Urine □ Sputum □ Stool □ Swab (site)_____ □ Wound/Lesion(Site)_____ □ Respiratory_____

□ Tissue (type) _____□ Body Fluid (type) _____ □ Other_____

Organism Suspected: _____ **Submitted on** (type of media) _____

Specimen or Reference Culture for TB or other AFB (*Mycobacterium* spp.)

Date Specimen Collected: (1) ____/____/____ (2) ____/____/____ (3) ____/____/____
mm dd yyyy mm dd yyyy mm dd yyyy

Specimen Source: □ Spontaneous Sputum □ Induced Sputum □ Bronchial Wash/BAL □ Pleural Fluid □ CSF □ Peritoneal Fluid
□ Lymph Node □ Blood □ Urine □ Stool □ Tissue (type) _____ □ Other_____

Sputum Type: □ Raw □ Partially processed □ Processed □ Postmortem

Organism Suspected: _____**Submitted on** (type media) _____

Additional testing requested: □ 2nd line drugs _____

Information to be included on final report as per request of submitter: