

STATE LAB
Use Only

Laboratories Administration MDH
1770 Ashland Ave • Baltimore, MD 21205
443-681-3800
<http://health.maryland.gov/laboratories/>
Robert A. Myers, Ph.D., Director



INFECTIOUS AGENTS: CULTURE/DETECTION

TYPE OR PRINT REQUIRED INFORMATION OR PLACE LABELS ON BOTH COPIES

<input type="checkbox"/> EH <input type="checkbox"/> FP <input type="checkbox"/> MTY/PN <input type="checkbox"/> NOD <input type="checkbox"/> STD/STI <input type="checkbox"/> TB <input type="checkbox"/> CD <input type="checkbox"/> COR	Patient SS # (last 4 digits)
Health Care Provider/ Facility	Last Name <input type="checkbox"/> SR <input type="checkbox"/> JR <input type="checkbox"/> Other
Address	First Name M.I.
City County	Date of Birth (mm/dd/yyyy) / /
State Zip Code	Address
Contact Name	City County
Phone # Fax #	State Zip Code
Test Request Authorized by	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender M to F <input type="checkbox"/> Transgender F to M	Ethnicity: Hispanic or Latino Origin? <input type="checkbox"/> Yes <input type="checkbox"/> No
Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White	
MRN/Case #	Dept. of Corrections # Outbreak # Submitter Lab #
Date Collected:	Time Collected: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Onset Date: ____/____/____
Reason for Test: <input type="checkbox"/> Screening <input type="checkbox"/> Diagnosis <input type="checkbox"/> Contact <input type="checkbox"/> Test of Cure <input type="checkbox"/> 2-3 Months Post Rx <input type="checkbox"/> Suspected Carrier <input type="checkbox"/> Isolate for ID <input type="checkbox"/> Release	
Therapy/Drug Treatment: <input type="checkbox"/> No <input type="checkbox"/> Yes Therapy/Drug Type: Therapy/Drug Date: ____/____/____	

SPECIMEN SOURCE CODE		SPECIMEN SOURCE CODE		SPECIMEN SOURCE CODE	
BACTERIOLOGY		PARASITOLOGY		SPECIAL BACTERIOLOGY	
Bacterial Culture - Routine		Blood Parasites _____ Country visited outside US: _____		Legionella Culture	
<i>Bordetella pertussis</i>		Ova & Parasites Immigrant? <input type="checkbox"/> Yes <input type="checkbox"/> No		Leptospira	
Group A Strep-Clinical		Cryptosporidium		Mycoplasma (Outbreak Investigation Only)	
Group B Strep Screen-Clinical		Cyclospora/Isospora		RESTRICTED TESTS <small>Pre-approved submitters only</small>	
<i>C. difficile</i> Toxin		Microsporidium		<i>Chlamydia trachomatis</i> /GC NAAT	
Diphtheria		Pinworm		**Norovirus-Outbreak Number Required	
Foodborne Pathogens (<i>B. cereus</i> , <i>C. perfringens</i> , <i>S. aureus</i>)		VIROLOGY		QuantIFERON Incubation: Time Began: ____ a.m. p.m. Time ended: ____ a.m. p.m.	
Gonorrhea Culture: Incubated? <input type="checkbox"/> Yes <input type="checkbox"/> No Hours Incubated: ____		<i>Chlamydia trachomatis</i> Culture		Antibiotic Resistance Lab Network- ARLN	
MRSA (rule out)		Cytomegalovirus (CMV)		Carbapenem Resistance Reference	
VRE (rule out)		Herpes Simplex Virus (Types 1 & 2)		Yeast Culture Reference	
ENTERIC INFECTIONS		Varicella (VZV)		Aspergillus fumigatus Azole Testing	
Campylobacter		Enterovirus*		OTHER TESTS FOR INFECTIOUS AGENTS	
<i>E. coli</i> O 157 typing/shiga toxins		COVID-19 (SARS-CoV-2)*		Test Name: _____	
Enteric Culture - Routine (Salmonella, Shigella, <i>E. coli</i> O157, Campylobacter)		Influenza (Types A & B)*		Prior arrangements have been made with the following MDH Labs Administration employee: _____	
Salmonella typing		POC Testing Method: _____ Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive infA <input type="checkbox"/> Positive infB Patient admitted to hospital? <input type="checkbox"/> No <input type="checkbox"/> Yes Subtype (If applicable): _____		Specimen Receipt Temperature (For MDH Lab Use ONLY):	
Shigella typing		NIRV (Non-Influenza Respiratory Viruses)* (Might include: Adenovirus, Human Metapneumovirus (hMPV), Respiratory Syncytial Virus (RSV), and Parainfluenza viruses 1 - 3)		_____ °C	
<i>Vibrio</i>				SPECIMEN SOURCE CODES PLACE CODE IN BOX NEXT TO TEST	
Yersinia				B Blood Specimen SP Sputum Specimen	
REFERENCE MICROBIOLOGY		*MIGHT INCLUDE RESPIRATORY SCREENING PANEL		BAL Bronchoalveolar lavage fluid sample T Throat Swab	
ABC's (BIDS) # _____ Organism: _____		Comments: _____		BW Bronchial Washings URE Urethral Swab	
Bacteria Referred Culture for ID Specify: _____				CSF Cerebrospinal Fluid Sample UFV Urine (1 st Void)	
MYCOBACTERIOLOGY/AFB/TB				CX Cervical Swab UCC Urine (Clean Catch)	
AFB/TB Culture and Smear				N Nasal Swab V Vaginal Swab	
AFB/TB Referred Isolate for ID				NP Nasopharyngeal Swab W Wound Swab	
<i>M. tuberculosis</i> referred Isolate for genotyping				P Penis Swab O Other: _____	
NUCLEIC Acid Amplification Test for <i>M. tuberculosis</i> Complex (GeneXpert)				R Rectum Swab S Stool Specimen	

Submitted For Regulatory Compliance and/or Surveillance
(Test Result(s) Not Issued)**

Surveillance Program (If Applicable):

**Must also mark a test condition

CLINIC CODES

EH – Employee Health
FP – Family Planning
MTY/PN – Maternity/Prenatal
NOD – Nurse of Day
STD/STI – Sexually Transmitted Disease/Infections
TB- Tuberculosis
CD- Communicable Disease
COR – Correctional Facility

Do not mark a box if clinic type does not apply

COMPLETING FORM

Press firmly – two part form

Type or print legibly

Printed labels are recommended

Please place labels on all copies of the form

Print or type the name of the person authorized to order test(s)
(This may be added to the pre-printed label.)

Collection date and time are required by law.
WRITE SPECIMEN CODE in box next to test.

Specimen/samples cannot be processed without a requested test.

****NOROVIRUS – Outbreak Number Required**

Appropriate for outbreak and epidemiological investigations **only**.

A MDH outbreak number is required.

Contact your local health department for a MDH outbreak number.

**Questions/comments on the use of the specimen bags/storage/shipping or completing the form contact:
Accessioning Unit 443-681-3842 or 443-681-3793**

To order collection kits and/or specimen collection supplies:

Contact Information:

Outfit Unit 443-681-3777 or Fax 443-681-3850

E-mail mdhlabs.outfits@maryland.gov

For specific test requirements refer to:

“Guide to Public Health Laboratory Services”

Available Online:

health.maryland.gov/laboratories/Pages/home.aspx

LABELING SPECIMENS/SAMPLES

Printed labels with all required patient information are recommended.

Print patient name, date of birth.
Print date and time the specimen was collected.

DO NOT cover expiration date of collection container.

Write specimen source on the collection container(s).

PACKAGING SPECIMENS FOR TRANSPORT

Never place specimens with different temperature requirements in the same bio-bag.

Review the Test Request Form to verify completeness including that the desired test(s) has/have been marked.

Use a separate bio-bag for each form and each temperature requirement. Place the specimen container in the zip lock portion of the bio-bag and seal it closed. Place the folded Test Request Form in the outside pocket of the bio-bag.

If multiple specimen containers are required for various tests marked on 1 form, place each container in a separate bio-bag to protect it from leakage/breakage of the other containers. Then place them all into an outer bio-bag with the Test Request Form in the pocket.

Verify that all specimen containers have been labeled as described above.

URINE SPECIMENS – Refrigerate PACKAGING AND SHIPPING

Double bag urine containers. Include absorbent material in the inner bio-bag and express air before sealing. Place this in a second bio-bag with the folded Test Request Form in the pocket of the outer bio-bag. Transport at refrigerated temperature.