Commonwealth of Virginia
Department of General Services
Division of Consolidated Laboratory Services
Richmond, Virginia

# DCLS Test Request Form

***For assistance, please refer *to Instructions for Completing DCLS Test Request Form* (Qualtrax ID # 34961)***

| PATIENT INFORMATION | | | SUBMITTER INFORMATION | |
|---|---|---|---|---|
| **Last Name**: | | | **Submitting Facility**: | |
| **First Name**: | | M.I. | Address: | |
| **Birth Date:** / / | ☐ Male ☐ Female | | City: | |
| Address: | | | State: | Zip code: |
| City: | State: | Zip code: | Phone: | Fax: |
| County: | MRN: | | Attending Clinician: | |
| Patient ID: | External ID: | | Attending Clinician Phone: | |
| Race: | Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino | | Public Health Dept Contact: | |
| Phone: | Pregnant: ☐ Yes ☐ No | | Public Health Contact Phone: | |

## PATIENT MEDICAL HISTORY

Disease Suspected or Diagnosis:

Date of Onset: / / | Deceased Date: / /

Signs/Symptoms: ☐ *Asymptomatic* ☐ *Abdominal Pain* ☐ *Cough* ☐ *Diarrhea* ☐ *Fever* ☐ *Headache* ☐ *Malaise/Fatigue* ☐ *Myalgia* ☐ *Pneumonia* ☐ *Rash* ☐ *Vomiting* ☐ *Other:*

Recent Exposure: ☐ *Sexual Contact* ☐ *Birds* ☐ *Ticks* ☐ *Mosquitos* ☐ *Other:*

Vaccine Administered: | Vaccine Administration Date: / /

Antibiotics/Antiviral Used: | Antibiotics/Antiviral Start Date: / /

Origin country (if not USA):

Recent Countries visited outside USA: | Dates: / / to / /

Recent States visited inside USA: | Dates: / / to / /

## OUTBREAK INFORMATION

Outbreak Related? ☐ *Yes* ☐ *No* | VDH Designated Outbreak #:

Role of Patient *(ex. Food handler, daycare provider):*

## SPECIMEN COLLECTION INFORMATION

**Date Collected**: / / | Submitted On (ex. media type, collection container):

**Time Collected**: : (military time) | Organism Suspected:

Reason for Test Request: ☐ *Isolate for ID/Confirmation* ☐ *VDH Reportable Disease Compliance* ☐ *Surveillance* ☐ *Diagnosis* ☐ *Contact/Suspected Carrier* ☐ *Clearance/Release* ☐ *Send Out / Diagnosis* ☐ *Other:*

**Specimen Source**: ☐ *Blood* ☐ *Serum* ☐ *CSF* ☐ *Urine* ☐ *Stool* ☐ *Buccal Swab* ☐ *Sputum* ☐ *Bronchial Wash* ☐ *BAL* ☐ *Nasopharyngeal Swab* ☐ *Oropharyngeal/Throat Swab* ☐ *Tissue - type:* ☐ *Body Fluid - type:* ☐ *Wound - site:* ☐ *Other Swab – site:* ☐ *Other:*

Follow-up specimen? ☐ *Yes* ☐ *No* | CIDT Specimen? ☐ *Yes* ☐ *No*

PulseNet referral? ☐ *Yes* ☐ *No* | Date PulseNet specimen received: / /

Submitter Test Method for ID/Detection:

Submitter Test Method for AST (if applicable):

Rapid Test(s) Used (if applicable): | Rapid Test Results:

| ADDITIONAL INFORMATION | ***Place Medical Patient Label, if applicable*** | ***DCLS STATE LAB USE ONLY*** |
|---|---|---|
| | | |

**Patient Name / Identifier** _____ **Date of Birth** ____ / ____ / _____

## TEST REQUEST (Place check in box next to desired test)

### Viral Testing

- ☐ Influenza detection/subtyping ☐ PCR ☐ Viral Culture
- ☐ Influenza A, un-subtypeable
- ☐ Novel Influenza
- ☐ Highly Pathogenic Avian Influenza (HPAI)
- ☐ Measles (Rubeola) * ☐ PCR ☐ Viral Culture ☐ Serology
- ☐ Mumps * ☐ PCR ☐ Viral Culture ☐ Serology
- ☐ Varicella Zoster Virus (VZV) * ☐ PCR ☐ Viral Culture
- ☐ Smallpox (Variola virus) *†
- ☐ Smallpox Vaccine Adverse Event (Vaccinia virus) *
- ☐ WNV (West Nile Virus), EEE (Eastern Equine Encephalitis), SLE (Saint Louis Encephalitis, LAC (La Crosse Encephalitis)
- ☐ Chikungunya ☐ PCR ☐ Serology
- ☐ Dengue ☐ PCR ☐ Serology
- ☐ Zika ☐ PCR ☐ Serology
- ☐ Other Arbovirus:
- ☐ Ebola Virus *
- ☐ Coronavirus infection * Suspected Virus:
- ☐ Viral Culture for ID Suspected ID:

### Biothreat Rule Out / Confirmatory Testing

- ☐ Anthrax *(Bacillus anthracis)*†^
- ☐ Botulism (*Clostridium botulinum*) *†
- ☐ Brucellosis *(Brucella* species)† ☐ PCR ☐ Serology
- ☐ *Burkholderia mallei / pseudomallei*†
- ☐ Plague *(Yersinia pestis)*†
- ☐ Q fever *(Coxiella burnetii)*†
- ☐ Tularemia *(Francisella tularensis)*†

### Enteric Culture / ID / Detection††

- ☐ *Campylobacteriosis (Campylobacter* species)
- ☐ Enteric Screen Culture (VDH request only)
- ☐ Enterotoxigenic *B. cereus* (VDH request only)
- ☐ Enterotoxigenic *C. perfringens* (VDH request only)
- ☐ Enterotoxigenic *S. aureus* (VDH request only)
- ☐ Norovirus (VDH request only)
- ☐ Salmonellosis *(Salmonella* species)
- ☐ Shiga toxin-producing *Escherichia coli* infection (STEC)
- ☐ Shigellosis *(Shigella* species)
- ☐ Vibriosis *(Vibrio* species) / Cholera *(Vibrio cholerae O1/O139)*
- ☐ Yersiniosis *(Yersinia* species) (other than *pestis*)

### Send Out Testing^^

- ☐ Test Request:
- ☐
- ☐

### Bacteriology ID / Detection

- ☐ PulseNet Sample Submitter Key ID #:
- ☐ Bacterial isolate for ID Suspected ID:
- ☐ Bacterial Meningitis (PCR)
- ☐ Carbapenem Resistant Organism**
  Suspected ID:
- ☐ Diphtheria *(Corynebacterium diphtheriae)*
- ☐ *Haemophilus influenzae* infection, invasive
- ☐ Listeriosis *(Listeria monocytogenes)*
- ☐ Meningococcal disease *(Neisseria meningitidis)*
- ☐ Pertussis / *Bordetella* species ☐ Culture ☐ PCR
- ☐ Streptococcal disease, Group A (*S. pyogenes*), invasive
- ☐ Vancomycin-intermediate/resistant *S. aureus* (VISA/VRSA)**
- ☐ *Vibrio* species
- ☐ Other:

### Mycology

- ☐ Actinomycete for ID Suspected ID:
- ☐ *Candida* species ☐ *C. auris* ☐ *C. haemulonii*
- ☐ Mold for ID Suspected ID:
- ☐ Yeast isolate for ID Suspected ID:

### Mycobacteriology / AFB

- ☐ *Mycobacterium tuberculosis* complex (compliance)
- ☐ *M. tuberculosis* complex Genotyping (VDH request only)
- ☐ Nontuberculous Mycobacteria ID (VDH request only)

### Miscellaneous

- ☐ **Congenital Cytomegalovirus – Newborn Screening**
  - Date of Failed Hearing Test: / /
  - External ID #:
  - Mother's Name:
  - Mother's Date of Birth: / /
  - Pediatrician Name:
  - Pediatrician Phone:
  - Pediatrician Address:
  - City: State: Zip code:
- ☐ **Malaria (EDTA Blood specimen only)**
- ☐ **Rubella Immunity Screening**
- ☐ **Other:**

- ☐ **Adult Sickle Cell**
  - Previous transfusion?
  - Transfusion Date: / /
  - Testing Reason: ☐ Routine ☐ Premarital ☐ Prenatal ☐ Family Planning ☐ Family Study ☐ Amnio Patient
  - ☐ Confirm known disease or trait ☐ Other:
- ☐ **ABO Testing – Blood Group and Rh Type**
  - Was Rhogam given? ☐ Yes ☐ No
  - If yes, Testing date: / /
  - Was a previous antibody identified? ☐ Yes ☐ No
  - If so, what was the antibody?

***** VDH approval is required prior to submission.

**†** Possible Select Agent – Notification and consultation with DCLS is required prior to submission.

****** Submission must include a copy of laboratory susceptibility testing results.

**††** Submission should include a copy of laboratory CIDT report for specimens, if applicable.

**^** Routine rule out testing of *Bacillus* species does **NOT** require prior notification or consultation with DCLS.

**^^** Specimens for Send Out Testing may require additional documentation. Please consult with DCLS prior to submission.