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

Instructions for Completing DCLS Test Request Form

PURPOSE

To be used when requesting testing of biological and potentially pathogenic agents at the Division of Consolidated Laboratory Services.

FORM

This is an Instructional document for completion of the 2-page *DCLS Test Request Form* (Qualtrax ID # 16857).
A Fillable PDF version is available online:
https://dgs.virginia.gov/division-of-consolidated-laboratory-services/resources/submission-forms

Patient Information

Complete the relevant fields for the Patient, including Medical Record Number (MRN#) and Patient ID, if available. If Race is applicable to testing, enter the appropriate abbreviation:

1) BLK- Black
2) WHT- Caucasian
3) ASIAN- Chinese, Filipino, Indian, Japanese, Korean, Pakistani, Thai, Vietnamese
4) AMER. INDIAN- American Indian, Alaskan Native
5) MIXED/OTHER– Biracial, Mixed, Unknown

PATIENT INFORMATION		
Last Name:		
First Name:		M.I.
Birth Date: / /	☐Male ☐Female	
Address:		
City:	State:	Zip code:
County:	MRN:	
Patient ID:	External ID:	
Race:	Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Latino	
Phone:	Pregnant: ☐Yes ☐No	

Submitter Information

Enter the name and contact information of the Healthcare Facility where the Patient is being treated. Provide Contact info, should a follow-up need to be obtained. Submitter has the option to enter the name and phone number of the Attending Clinician. If applicable, enter the name and phone number of the Public Health Contact.

SUBMITTER INFORMATION	
Submitting Facility:	
Address:	
City:	
State:	Zip code:
Phone:	Fax:
Attending Clinician:	
Attending Clinician Phone:	
Public Health Dept Contact:	
Public Health Contact Phone:	

Patient Medical History / Outbreak Information

Complete the fields for Patient Medical History, if applicable to Patient, additional instructions for select fields listed below:
***Note:** Travel history **required** for Test Requests of "**Influenza A**" and "**Novel Influenza**".

❶ **DATE OF ONSET –** Provide the Date (mm/dd/yyyy) that the Patient began to display relevant signs/symptoms.

❷ **SIGNS/SYMPTOMS –** Select checkboxes of all relevant signs/symptoms that the Patient has exhibited during ailment. If experiencing additional symptoms not listed, select the "Other" checkbox and enter symptoms in the space provided.

❸ **RECENT EXPOSURE –** Select checkboxes for any potential exposures. If an appropriate exposure is not listed, select "Other" checkbox and enter the suitable exposure.

❹ **VACCINE ADMINISTERED, DATE –** List all relevant vaccines to the Patient and date(s) administered.

❺ **ANTIBIOTICS / ANTIVIRAL USED, DATE –** List all relevant antibiotics/antivirals administered during course of Patient ailment, and Start Date.

❻ **ORIGIN COUNTRY –** If not from United States, list Patient's Country of Origin.

❼ **RECENT COUNTRIES / STATES VISITED… (with DATES: from/to) –** List all Countries recently visited outside USA, include date ranges of travel. List all U.S. States recently visited outside Virginia, include date ranges of travel.

❽ **OUTBREAK RELATED? –** If Patient Case is a suspected outbreak, select "YES" checkbox, and proceed to questions.

PATIENT MEDICAL HISTORY		
Disease Suspected or Diagnosis:		
❶ Date of Onset: / /	Deceased Date: / /	
❷ Signs/Symptoms: ☐ *Asymptomatic* ☐ *Abdominal Pain* ☐ *Cough* ☐ *Diarrhea* ☐ *Fever* ☐ *Headache* ☐ *Malaise/Fatigue* ☐ *Myalgia* ☐ *Pneumonia* ☐ *Rash* ☐ *Vomiting* ☐ *Other:*		
❸ Recent Exposure: ☐ *Sexual Contact* ☐ *Birds* ☐ *Ticks* ☐ *Mosquitos* ☐ *Other:*		
❹ Vaccine Administered:	Vaccine Administration Date: / /	
❺ Antibiotics/Antiviral Used:	Antibiotics/Antiviral Start Date: / /	
❻ Origin country (if not USA):		
❼ Recent Countries visited outside USA:	Dates: / / to / /	
Recent States visited inside USA:	Dates: / / to / /	
OUTBREAK INFORMATION		
❽ Outbreak Related? ☐ *Yes* ☐ *No*	VDH Designated Outbreak #:	
Role of Patient *(ex. Food handler, daycare provider):*		

Specimen Collection Information

Complete the fields for Specimen Collection Information, if applicable, additional instructions for select fields listed below:

❾ **DATE COLLECTED –** Provide the Date (mm/dd/yyyy) that the Specimen was collected by the Submitter.

❿ **SUBMITTED ON –** Provide the media type or container type that the Specimen was submitted on by the Submitter.

⓫ **TIME COLLECTED –** Provide the Time (hh:mm, military time) that the Specimen was collected by the Submitter.

⓬ **REASON FOR TEST REQUEST –** Select the checkbox of the relevant reason(s) for the Test Request. If an appropriate reason is not found, select the "Other" checkbox and enter the suitable reason in the space.

⓭ **SPECIMEN SOURCE –** Select the checkbox of the relevant Specimen Source for the Test Request. If a Source is not listed, select the "Other" checkbox and enter a suitable Specimen Source in the space provided.

⓮ **CIDT SPECIMEN –** Select the checkbox if sample is a Culture-Independent Diagnostic Test, e.g., a direct specimen PCR test or enzyme immunoassay.

⓯ **PULSENET REFERRAL –** Mark the checkbox and date received if sample is a PulseNet referral for Whole Genome Sequencing.

⓰ **SUBMITTER TEST METHOD FOR ID/DETECTION / AST –** If Submitter has conducted initial testing for ID/Detection, or AST, provide test method performed.

⓱ **RAPID TEST(S) USED (IF APPLICABLE) –** Enter Rapid Diagnostic Tests used (e.g., Influenza, RSV, etc.), and results.

SPECIMEN COLLECTION INFORMATION	
❾ **Date Collected:** / /	❿ Submitted On (ex. media type, collection container):
⓫ **Time Collected:** : (military time)	Organism Suspected:
⓬ Reason for Test Request: ☐ *Isolate for ID/Confirmation* ☐ *VDH Reportable Disease Compliance* ☐ *Surveillance* ☐ *Diagnosis* ☐ *Contact/Suspected Carrier* ☐ *Clearance/Release* ☐ *Send Out / Diagnosis* ☐ *Other:*	
⓭ **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*	⓮ CIDT Specimen? ☐ *Yes* ☐ *No*
⓯ PulseNet referral? ☐ *Yes* ☐ *No*	Date PulseNet specimen received: / /
⓰ Submitter Test Method for ID/Detection:	
Submitter Test Method for AST (if applicable):	
⓱ Rapid Test(s) Used (if applicable):	Rapid Test Results:

Additional Information Section

ADDITIONAL INFORMATION – Provide any additional info that Submitter would like to include on the Final Report.

Test Request

Examine the Test Request List on Page 2 of the Submitter Form, and place a check next to the desired Test. Complete any additional Test Request information, including checkboxes for test type (PCR, Viral Culture, etc.), for "Testing Reason", for sub-species, or a fill-in blank for "Testing Date", etc. When completing the "Suspected…" fields, list the suspected pathogen in the space provided if possible. Example: "Coronavirus infection - Suspected Virus: **SARS-COV-2**).

Example: To order a Yeast isolate for ID:

1.) Mark the checkbox to the left of desired Test.
2.) For Suspected ID: fill in blank with pathogen's name or description e.g., *Cryptococcus neoformans.*

Mycology		
☐	Actinomycete for ID	Suspected ID:
☐	*Candida* species	☐ *C. auris* ☐ *C. haemulonii*
☐	Mold for ID	Suspected ID:
✓	Yeast isolate for ID	Suspected ID: ***Cryptococcus neoformans***