

INFECTIOUS DISEASE TEST REQUEST FORM

UTAH PUBLIC HEALTH LABORATORY 4431 SOUTH 2700 WEST TAYLORSVILLE, UTAH 84129 TELEPHONE: (801) 965-2400 FAX: (801) 536-0473 http://health.utah.gov/lab/infectious-diseases	FOR UPHL USE ONLY	LAB# _____ DATE STAMP _____
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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
			____/____/____		M F

LAST NAME	FIRST NAME	Is Patient Insured? <input type="checkbox"/> Yes <input type="checkbox"/> No	STI TESTING ONLY: Is patient MSM? <input type="checkbox"/> Yes <input type="checkbox"/> No
		If Yes, will insurance be billed? <input type="checkbox"/> Yes <input type="checkbox"/> No	

PATIENT ID #	ETHNICITY	RACE	
	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> White <input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native

PROVIDER INFORMATION	SPECIMEN COLLECTION DATE AND TIME
Provider Code: _____ Physician: _____ Provider Phone: _____ Provider Email: _____ Secure Fax #: _____	(mm/dd/yy) ____/____/____ Time: _____

SPECIMEN SOURCE/SITE (CHOOSE 1):

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

BIOTERRORISM TESTS (Notify lab before submitting) BACTERIOLOGY/TUBERCULOSIS TESTS IMMUNOLOGY TESTS

[] Isolate [] Original Material	[] Isolate [] Original Material	[] QuantIFERON-TB Gold
<input type="checkbox"/> Bacillus anthracis (Detection/ID) <input type="checkbox"/> Brucella species (Detection/ID) <input type="checkbox"/> Brucella antibody <input type="checkbox"/> Burkholderia mallei/pseudomallei (Detection/ID) <input type="checkbox"/> Clostridium botulinum culture & toxin <input type="checkbox"/> Coxiella burnetii (Detection) <input type="checkbox"/> Ebola virus (Detection) <input type="checkbox"/> Francisella tularensis (Detection/Identification) <input type="checkbox"/> F. tularensis antibody <input type="checkbox"/> MERS CoV <input type="checkbox"/> Orthopox viruses Detection Virus Suspected: _____ <input type="checkbox"/> Rickettsia (Detection) <input type="checkbox"/> Yersinia pestis (Detection/Identification) <input type="checkbox"/> Yersinia pestis antibody <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Salmonella <input type="checkbox"/> Shigella <input type="checkbox"/> E. coli O157 <input type="checkbox"/> EHEC/STEC <input type="checkbox"/> Campylobacter <input type="checkbox"/> Haemophilus Influenzae <input type="checkbox"/> Neisseria gonorrhoea <input type="checkbox"/> Neisseria meningitidis <input type="checkbox"/> OME Culture <input type="checkbox"/> CRE/CRPA/CRAB <input type="checkbox"/> Vibrio/Plesiomonas/Aeromonas <input type="checkbox"/> Other (specify): _____ Tuberculosis Specimen <input type="checkbox"/> GeneXpert <input type="checkbox"/> Mycobacterial culture Has patient received chest x-ray? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, did patient show signs of cavitary disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Mycobacterial referral Presumptive ID: _____ <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> REQUIRED information: Blood draw date/time: _____ Incubation at 37°C completed? <input type="checkbox"/> Yes <input type="checkbox"/> No Signature: _____ Incubation start date/time: _____ Incubation end date/time: _____ <input type="checkbox"/> Syphilis IgG EIA (includes confirmatory testing) <input type="checkbox"/> Suspect acute infection/previous positive <input type="checkbox"/> HIV Antigen/Antibody (includes confirmatory testing) <input type="checkbox"/> Previous positive <input type="checkbox"/> Hepatitis C Antibody <input type="checkbox"/> HCV RNA Testing if Positive <input type="checkbox"/> Hepatitis B Antibody <input type="checkbox"/> Hepatitis B Antigen (includes confirmatory testing)

ADDITIONAL INFORMATION VIROLOGY TESTS

ADDITIONAL INFORMATION	VIROLOGY TESTS	
<input type="checkbox"/> Other Disease Suspected: _____ <input type="checkbox"/> Referral Test (additional form(s) REQUIRED) *Contact UPHL for additional form(s)	Aptima NAAT <input type="checkbox"/> C. trachomatis and N. gonorrhoea by NAAT <input type="checkbox"/> Patient is partner of a 15-24 year old female Virus Identification <input type="checkbox"/> Respiratory Panel (FilmArray) <input type="checkbox"/> Herpes Simplex/Varicella zoster PCR (HSV-1, HSV-2, VZV) <input type="checkbox"/> Triplex PCR (Zika, Dengue, Chikungunya Viruses) Influenza PCR <input type="checkbox"/> Influenza A & B virus PCR (with subtyping/genotyping)	<input type="checkbox"/> Hantavirus (Sin Nombre) IgG/IgM <input type="checkbox"/> Acute Serum (mm/dd/yy) ____/____/____ <input type="checkbox"/> Convalescent serum (mm/dd/yy) ____/____/____ <input type="checkbox"/> West Nile virus IgM (Human) <input type="checkbox"/> Zika virus IgM

COMMENTS: _____