

# INFECTIOUS DISEASE TEST REQUEST FORM

<b>UTAH PUBLIC HEALTH LABORATORY</b>  4431 SOUTH 2700 WEST TAYLORSVILLE, UTAH 84129 TELEPHONE: (801) 965-2400 FAX: (801) 536-0473 http://health.utah.gov/lab/infectious-diseases	<b>FOR UPHL USE ONLY</b>	LAB# _____   DATE STAMP _____
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PLEASE PRINT CLEARLY AND FILL OUT AS COMPLETELY AS POSSIBLE.

<b>PATIENT INFORMATION:</b>					
PATIENT STATE OF RESIDENCE	PATIENT COUNTY OF RESIDENCE	ZIP CODE	DATE OF BIRTH (mm/dd/yyyy)	AGE	SEX M F
LAST NAME	FIRST NAME	Is Patient Insured? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, will insurance be billed? <input type="checkbox"/> Yes <input type="checkbox"/> No		STI TESTING ONLY: Is patient MSM? <input type="checkbox"/> Yes <input type="checkbox"/> No	
PATIENT ID #	ETHNICITY <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	RACE <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or other Pacific Islander			
PROVIDER INFORMATION Provider Code: _____			SPECIMEN COLLECTION DATE AND TIME (mm/dd/yy) ____/____/____ Time: _____		
Physician: _____			Provider Phone: _____		
Provider Email: _____			Secure Fax #: _____		
<b>SPECIMEN SOURCE/SITE (CHOOSE 1):</b>					
<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): _____					
<b>BIOTERRORISM TESTS (Notify lab before submitting)</b>		<b>BACTERIOLOGY/TUBERCULOSIS TESTS</b>		<b>IMMUNOLOGY TESTS</b>	
<input type="checkbox"/> Isolate <input type="checkbox"/> Original Material  <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"/> 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"/> Other (specify): _____		<input type="checkbox"/> Isolate <input type="checkbox"/> Original Material  <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): _____  <b>Tuberculosis Specimen</b> <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"/> QuantIFERON-TB Gold  <b>REQUIRED information:</b> 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"/> Antibody to Hepatitis B Surface Antigen (Anti-HBs) <input type="checkbox"/> Total Antibody to Hepatitis Core Antigen (total Anti -HBc) <input type="checkbox"/> Hepatitis B Antigen HBsAg  <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	
<b>ADDITIONAL INFORMATION</b>		<b>VIROLOGY TESTS</b>			
<input type="checkbox"/> Other Disease Suspected: _____  <input type="checkbox"/> Referral Test (additional form(s) <b>REQUIRED</b> ) <b>*Contact UPHL for additional form(s)</b>		<input type="checkbox"/> C. trachomatis and N. gonorrhoea by NAAT <input type="checkbox"/> Patient is partner of a 15-24 year old female <input type="checkbox"/> Mycoplasma genitalium by NAAT <input type="checkbox"/> Trichomonas vaginalis PCR <input type="checkbox"/> Respiratory Panel (FilmArray) <input type="checkbox"/> Herpes Simplex/Varicella zoster PCR (HSV-1, HSV-2, VZV) <input type="checkbox"/> Trioplex PCR (Zika, Dengue, Chikungunya Viruses) <input type="checkbox"/> Influenza A & B virus PCR (with subtyping/ genotyping)			
<b>COMMENTS:</b>					