Specimen Type: Check appropriate specimen and fill in requested information (Only one sample per form).

- Swab
  - ☐ Throat
  - ☐ Nasopharyngeal
  - ☐ Cervix
  - ☐ Urethra
  - ☐ Other: _____
- Chest fluid
  - ☐ Pleural
  - ☐ Peritoneal
- Bronch
  - ☐ BAL/Washing
  - ☐ Brushing
- ☐ Synovial fluid
  - Source: _____
- ☐ Serum
- ☐ Sputum
- ☐ Stool
- ☐ CSF
- ☐ Urine
- ☐ Blood
- ☐ Wound/Tissue/Biopsy
  - Source: _____
- ☐ Scrapings/Clippings
  - Source: _____
- ☐ Slides Only
  - Source: _____
- ☐ Other: _____

DATE COLLECTED: ____ / ____ / ____ (mm / dd / year)

PATIENT: _____ (last) _____ (first)

BIRTH DATE: ____ / ____ / ____ (mm / dd / year) SSN #: ___ – ___

ADDRESS: _____

CITY: _____ STATE: ____ ZIP: _____

PHONE: ( ) - GENDER: ☐ Female ☐ Male

RACE: ☐ White ☐ Black ☐ Asian ☐ American Indian / Alaskan Native ☐ Native Hawaiian / Pacific Islander ☐ Unknown

ETHNICITY: ☐ Hispanic ☐ Non Hispanic ☐ Unknown

PATIENT ID #: _____

CLINICIAN: _____ (please print last first) CLINICIAN ID #: _____

PHONE: ( ) - CLINICIAN'S Signature:

☐ As the clinician providing care to this patient, I request that this test be performed without charge to this patient because of the imminent and significant public health threat posed by the differential diagnosis.

Bacteriology Test Request Form

Test(s) Requested

Enterics
- ☐ Culture (includes Salm, Shig, Campy, Ecoli 0157, Yersinia, Aeromonas, Shigatoxin screen)
- ☐ Culture for Ecoli 0157 and other STEC only (includes Shigatoxin screen)
- GN Broth for STEC (for labs only)
  - ☐ Toxin Screen Positive
  - ☐ Not Tested
- ☐ Yersinia culture only
- ☐ Vibrio culture only
- ☐ Norovirus

Parasitology
- ☐ Routine O&P (concentration method only)
- ☐ Trichrome Stain
- ☐ Blood smear for parasites (includes malaria)
- Special stains
  - ☐ Cryptosporidium
  - ☐ Cyclospora
- ☐ Arthropod identification
- ☐ Parasite identification

Bacteriology
- Legionella
  - ☐ Culture (includes DFA)
  - ☐ PCR
  - ☐ Smear only
- ☐ Isolate identification (for labs only - complete section below)

Relevant Isolate Information (Isolate processing will be delayed until this information is received)
- Gram stain morphology: _____
- Atmospheric requirement
  - ☐ Aerobic ☐ Anaerobic ☐ Microaerophilic
- Agent suspected: _____

- ☐ Enteric Isolate Serotype (To satisfy Iowa Administrative Code)
  - Organism: _____
- Culture for Neisseria gonorrhoeae only
  - ☐ Routine
  - ☐ Test of cure
    - Antibiotics Used: _____

☐ PFGE (strain typing) of suspected nosocomial isolate

The following information must be provided or the isolate will not be tested
- Organism: _____
- Event (outbreak) designation for the facility: _____

Mycobacteriology
- ☐ AFB Culture (includes smear and susceptibility if M. Tb)
- ☐ AFB Isolate identification (check submission type below)
  - ☐ Liquid ☐ Slant
- ☐ NAAT (if submitting digested sediment you must provide the information below)
  - Smear Result (quantitative): _____
  - Date of digest/decon: ____ / ____ / ____ (mm / dd / year)

Mycology
- ☐ Fungal Culture (submission of clinical specimen)
- ☐ Fungal Isolate identification

Miscellaneous Culture
- ☐ Specify: _____

MEDICAID / MEDICARE INFORMATION

Patient's Medicaid/Medicare #: _____

Physician Provider #: _____

ICD9 Diagnosis Code (REQUIRED): _____

Referring Physician # (Medipass only): _____

If insurance is primary to Medicaid / Medicare

Insured's Name: _____ (please print)

Insured's ID#: _____

Insurance Company Name: _____

Insurance Company Address: _____

City: _____ State: ___ Zip: _____

Facility Name: _____

Address: _____

City: _____ State: ___ Zip: _____

Enter your facility address
Results are returned
to this address

State Hygienic Laboratory

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Fax #: 515-725-1642

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