Microbiology/Virology Test Requisition

Bureau of Laboratories   Michigan Department of Community Health

PO Box 30035   3350 North Martin Luther King Jr. Blvd.   Lansing Michigan 48909

Laboratory Records: 517-335-8059   Fax: 517-335-9871   Technical Information   517-335-8067   Web: HTTP://www.Michigan.gov/mdchlab

Date Received at MDCH	MDCH Sample #

AGENCY - SUBMITTER INFORMATION | **ENTER STARLIMS AGENCY CODE**

Return Results to: | FP O | STD O | Phone (24/7) | FAX

CONTACT PERSON/ REFERRING PHYSICIAN/ PROVIDER NAME | **NATIONAL PROVIDER IDENTIFIER:**

PATIENT INFORMATION - NAME (LAST, FIRST, MIDDLE INITIAL OR UNIQUE IDENTIFIER)   **Must Match Specimen Label Exactly**

SUBMITTER'S PATIENT #-IF APPLICABLE

PATIENT'S CITY-RESIDENCE | **ZIP CODE** | **GENDER** O Female O Male

RACE O BLACK/AA O WHITE O NATIVE AMERICAN OR ALASKAN O ASIAN O HAWAIIAN/PI O UNKNOWN O OTHER (SPECIFY):____________________

ETHNICITY HISPANIC O YES O NO O UNKNOWN; ARAB DESCENT O YES O NO O UNKNOWN | **DATE OF BIRTH** M M D D Y Y Y Y

SUBSCRIBER INFORMATION O MEDICAID O PLAN FIRST! O ADAP O DOC O OTHER ____________________

SUBSCRIBER #

SUBMITTER'S SPECIMEN # - IF APPLICABLE

DATE COLLECTED M M D D Y Y Y Y | TIME COLLECTED | O A.M. | O P.M.

INDICATE TEST REQUESTED **(complete specimen source information on back)**

SEROLOGY

- O ARBOVIRUS ENCEP. PANEL (IgM) §
- O *BRUCELLA* SEROLOGY
- O FUNGAL SEROLOGY COMPLEMENT FIXATION
- O FUNGAL IMMUNODIFFUSION
- O *FRANCISELLA* SEROLOGY
- O *LEGIONELLA* - HA
- O LYME DISEASE - EIA **Complete # 4 (reverse)**
- O MEASLES IgG
- O MUMPS IgG
- O RABIES AB SEROLOGY **Complete # 3 (reverse)**
- O RUBELLA IgG
- O TETANUS TOXIN EIA
- O VARICELLA ZOSTER IgG

SERUM STATUS - If Applicable

O Acute O Convalescent

§ May – October Includes Eastern Equine, California, St. Louis and West Nile. CSF only

MISCELLANEOUS

- O AUTOCLAVE TEST STRIPS
- O *LEGIONELLA* - DFA
- O LYME DISEASE-IFA (Tick)

SYPHILIS TESTING

- O SYPHILIS (USR Test)
- O SYPHILIS VDRL - CSF Only
- O SYPHILIS DFA **Complete # 2 (reverse)**
- O SYPHILIS FTA - ABS DS*
- O SYPHILIS IgM WESTERN BLOT*
- O SYPHILIS TP-PA*

(* Prior Approval Required)

HIV TESTING

- O HIV AB – Serum
- O HIV AB - Oral Mucosal Transudate
- O CD4/CD8 (EDTA whole blood)
- O HIV-1 VIRAL LOAD (EDTA plasma)
- O HIV-1 GENOTYPING (EDTA plasma)

HEPATITIS TESTING

- O HEPATITIS C SCREEN
- O HBsAg **Complete #1 (reverse)**
- O HEPATITIS B SURFACE AB (Anti-HBs)
- O HEPATITIS A VIRUS (IgM)

MICROBIOLOGY

- O AEROBIC ISOLATE ID **Complete # 5 (Reverse)**
- O AFB SUSCEPTIBILITY
- O AFB SLIDE/CULTURE-CLINICAL SPECIMEN
- O AFB Identification – Isolate ID
- O *C. trachomatis* (Non-culture)[1]
- O *E. coli* (SLT) TOXIN & SEROLOGY
- O ENTERIC BACTERIAL CULTURE
- O FOODBORNE ILLNESS - Stool or Food **Complete # 6 (Reverse)**
- O FUNGAL IDENTIFICATION– Isolate ID
- O *LEGIONELLA* CULTURE
- O *NEISSERIA GONORRHOEAE* - Isolation
- O *NEISSERIA* - REFERRED CULTURE
- O PARASITOLOGY – BLOOD
- O PARASITOLOGY – Stool
- O PARASITOLOGY – WORM
- O *PERTUSSIS* PCR
- O *Salmonella/Shigella* SEROTYPING-Human

VIRAL CULTURE

- O ENTEROVIRUS CULTURE
- O VIRAL RESPIRATORY PANEL

Tests That Require Prior MDCH Approval

- O BACTERIAL TYPING – PFGE **Complete # 6 (Reverse)**
- O BOTULISM TOXIN
- O ENTEROVIRUS - PCR
- O MUMPS - CULTURE
- O MUMPS - PCR
- O MEASLES IgM @ CDC
- O NOVEL INFLUENZA A - PCR
- O NOROVIRUS – PCR **Complete # 6 (Reverse)**
- O *PERTUSSIS* CULTURE
- O RUBELLA IgM
- O *SALMONELLA* SEROTYPING (Non-Human)
- O TOXIC SHOCK TESTING
- O Other: ________________
- O Other: ________________

Instructions for completion: Completely fill in the appropriate circle. For example, upon completion the circle should appear as ●, rather than ⊗.

INDICATE SPECIMEN SOURCE BELOW

O Bronchial	O Gastric	O Plasma	O Sputum	O Urine	O Whole Blood
O Cervix	O Nasopharyngeal	O Serum	O Throat	O Food - Specify:	
O CSF	O Oral Mucosal Transudate	O Stool	O Urethra	O Other - Specify: ____________________	

INDICATE TEST REASON BELOW

O Diagnosis	O Surveillance	O Outbreak (complete Section 6) O Other – Specify: ___________________
STD* O Symptoms O Prenatal Visit O Infected Partner O Partner Risk O History of STD (< 3years) O Age recommended for Testing O Retest		

1	**IF REQUESTING EXAMINATION FOR: HEPATITIS B COMPLETE ALL THAT APPLY**
O Pregnancy (HBsAg)	O Exposure to someone with Hepatitis B

2	**IF REQUESTING EXAMINATION FOR: SYPHILIS - DFA COMPLETE THIS SECTION**			
Duration of Lesion			O Days O Months O Years	Specify Site:

3	**IF REQUESTING EXAMINATION FOR: RABIES ANTIBODY SEROLOGY COMPLETE THIS SECTION**							
Date of Last Rabies Vaccination	M	M	D	D	Y	Y	Y	Y

4	**IF REQUESTING EXAMINATION FOR: LYME BORRELIOSIS COMPLETE THIS SECTION**								
ONSET DATE	M	M	D	D	Y	Y	Y	Y	State/County/Country of Exposure

EARLY DISEASE	O Erythema migrans O Symptoms (Specify): ____________ (5 cm at least in diameter) (Ex., Rash, Fever, Headache, Joint Pain)	LATE DISEASE	O Neurologic O Cardiologic O Rheumatologic

5	**IF REQUESTING EXAMINATION FOR: AEROBIC CULTURE COMPLETE ALL THAT APPLY**

O Aerobe O Microaerophile Gram O Positive O Negative O Variable O Rod O Coccus O Diplococcus

Bacterial Growth Char.: MacConkey O Pos O Neg Oxidase O Pos O Neg Catalase O Pos O Neg Dextrose O Oxidation O Fermentation

□ Other: ____

____

____

6	**IF REQUESTING EXAMINATION FOR: OUTBREAK INVESTIGATION COMPLETE THIS SECTION**							
ONSET DATE	M	M	D	D	Y	Y	Y	Y

OUTBREAK IDENTIFIER (Foodborne ONLY - If Applicable)	
ORGANISM SUSPECTED (If Applicable)	
MDCH Prior Approval: Name, date or code	

***Sexually Transmitted Diseases – Definitions**

Symptoms:	Patient requesting examination due to symptoms, or, symptoms discovered on examination.
Infected Partner:	Patient has known exposure to STD (self-reported or documented).
Partner Risk:	Patient has multiple sex partners.
History of STD:	Patient has been diagnosed with a sexually transmitted disease within last 3 years.
Prenatal Visit:	Patient examination is part of prenatal visit.
Age recommended:	Recommended age criteria for screening female patients is ≤ 24 for family planning clinics, adolescent and juvenile detention sites, and all ages for STD clinics.
"Plan First!" Clients:	A "Plan First!" client seeking family planning services will receive screening and teaching. As a Title X Standards & Guideline requirement, *Chlamydia trachomatis* and *Neisseria gonorrhoeae* screening must be offered to "Plan First!" clients < 24 years of age, prior to provision of a contraceptive method, if risk factors are reported.
Retest:	CDC recommends that women testing positive for *N. gonorrhea* and *Chlamydia trachomatis* be retested approximately 3 months after treatment. Providers are also strongly encouraged to retest all women treated for these infections whenever they seek medical care within the following 3-12 months, regardless of whether the patient believes her sex partners were treated.

[1]All tests positive for *Chlamydia* will automatically be tested for *N. gonorrhoeae.*