



SLD CLINICAL TEST REQUEST FORM

Scientific Laboratory Division
1101 Camino de Salud N.E.
Albuquerque, NM 87102

SLD LAB NO. ONLY
ONE FORM PER SPECIMEN

PLEASE PRINT LEGIBLY

SLD Form 101 v2.1

USER CODES →→

SLD _____ DATE _____
USE >>> <<<TIME _____
ONLY _____ STAMP _____

<input type="checkbox"/> 51000 (Epidemiology)	<input type="checkbox"/> 52325 (PHD: Adult Hepatitis)
<input type="checkbox"/> 52000 (PHD: General)	<input type="checkbox"/> 52330 (PHD: TB Program)
<input type="checkbox"/> 52110 (PHD: Prenatal)	<input type="checkbox"/> 51006 (EIP)
<input type="checkbox"/> 52120 (PHD: Family Plan)	<input type="checkbox"/> 70704 (OMI)
<input type="checkbox"/> 52340 (PHD: Refugee)	<input type="checkbox"/> Other: (Enter Number) _____

Please limit
to one code
per form

SUBMITTER INFORMATION

SUBMITTER CODE _____

FACILITY NAME _____

ADDRESS _____
Street or PO _____

City _____ State _____ Zip Code _____

PHONE () _____

ATTENTION: _____

PATIENT INFORMATION

PATIENT NAME _____
Last _____ First _____

GENDER MALE FEMALE TRANSGENDER

DATE OF BIRTH MM/ DD/ YYYY : ____/____/____

ADDRESS _____
Street or PO _____

City _____ State _____ Zip Code _____

PATIENT ID (MRN#) _____

SOCIAL SECURITY _____

OTHER ID (HIV#) _____

CLINICIAN NAME _____
Last _____ First _____

PHONE # () _____

RACE: Check all that apply.

American Indian/Alaskan Native Asian Black/African American

Native Hawaiian/Pacific Islander White Other

ETHNICITY: Hispanic Non-Hispanic

SPECIMEN INFORMATION

<input type="checkbox"/> Abscess	<input type="checkbox"/> Bronchial Biopsy	<input type="checkbox"/> Fluid (site): _____	<input type="checkbox"/> Oral Fluid	<input type="checkbox"/> Sputum, nebulized
<input type="checkbox"/> Ascites fluid	<input type="checkbox"/> Bronchial Wash	<input type="checkbox"/> Liver	<input type="checkbox"/> Pericardial fluid	<input type="checkbox"/> Throat swab
<input type="checkbox"/> Blood, femoral	<input type="checkbox"/> Bronchoalveolar lavage	<input type="checkbox"/> Lymph node	<input type="checkbox"/> Peritoneal fluid	<input type="checkbox"/> Throat wash
<input type="checkbox"/> Blood, heart	<input type="checkbox"/> Cervix	<input type="checkbox"/> Lung, left	<input type="checkbox"/> Pleural fluid	<input type="checkbox"/> Tissue (site): _____
<input type="checkbox"/> Blood, plasma	<input type="checkbox"/> CSF	<input type="checkbox"/> Lung, right	<input type="checkbox"/> Pleural Biopsy	<input type="checkbox"/> Tracheal aspirate
<input type="checkbox"/> Blood, serum	<input type="checkbox"/> Ear	<input type="checkbox"/> Nail (site): _____	<input type="checkbox"/> Rectum	<input type="checkbox"/> Urine
<input type="checkbox"/> Blood, whole	<input type="checkbox"/> Endocervix	<input type="checkbox"/> Nasopharyngeal swab	<input type="checkbox"/> Rectum/Vagina	<input type="checkbox"/> Urethra
<input type="checkbox"/> Bone	<input type="checkbox"/> Eye	<input type="checkbox"/> Nasopharyngeal wash	<input type="checkbox"/> Skin (site): _____	<input type="checkbox"/> Vagina
<input type="checkbox"/> Bone marrow	<input type="checkbox"/> Feces/Stool	<input type="checkbox"/> Nasal swab	<input type="checkbox"/> Spleen	<input type="checkbox"/> Wound (site): _____
<input type="checkbox"/> Brain	<input type="checkbox"/> Hair	<input type="checkbox"/> Nasal wash	<input type="checkbox"/> Sputum, natural	<input type="checkbox"/> Other: _____

SPECIMEN COLLECTION

Date/Time Collected ____/____/____ Military Time _____

End of Quantiferon ____/____/____

Incubation (TB Only) MM/ DD/ YYYY Military Time _____

SPECIMEN TYPE

Clinical

Reference

CLINICAL SYMPTOMS

Asymptomatic

Symptomatic: Date of onset: MM / DD / YYYY ____/____/____

ANALYSIS REQUESTED

<p>BACTERIOLOGY</p> <p><input type="checkbox"/> B. anthracis</p> <p><input type="checkbox"/> B. cereus/S. aureus</p> <p><input type="checkbox"/> Culture, OMI</p> <p><input type="checkbox"/> Culture, OMI anaerobic</p> <p><input type="checkbox"/> Campylobacter species: _____</p> <p><input type="checkbox"/> E. coli 0157:H7</p> <p><input type="checkbox"/> GC culture</p> <p><input type="checkbox"/> H. influenzae typing</p> <p><input type="checkbox"/> L. monocytogenes</p> <p><input type="checkbox"/> Legionella culture</p> <p><input type="checkbox"/> Necrotizing fasciitis</p> <p><input type="checkbox"/> N. meningitidis typing</p> <p>ID of Bacteria (specify)</p> <p><input type="checkbox"/> -Anaerobe _____</p> <p><input type="checkbox"/> -Gram negative _____</p> <p><input type="checkbox"/> -Gram positive _____</p> <p>EIP isolate (specify)</p> <p>____ -Group A Streptococcus</p> <p>____ -Group B Streptococcus</p> <p>____ -S. pneumoniae</p>	<p><input type="checkbox"/> Plague FA and culture</p> <p><input type="checkbox"/> Salmonella, serotype: _____</p> <p><input type="checkbox"/> Shigella, serotype: _____</p> <p><input type="checkbox"/> Shiga Toxin test/isolation</p> <p><input type="checkbox"/> Strep, Group B, isolation</p> <p><input type="checkbox"/> Tularemia culture</p> <p><input type="checkbox"/> Vibrio</p> <p><input type="checkbox"/> Yersinia enterocolitica: _____</p> <p><input type="checkbox"/> Other: _____</p>	<p>MYCOLOGY</p> <p><input type="checkbox"/> Aerobic actinomycetes</p> <p><input type="checkbox"/> Coccidioides</p> <p><input type="checkbox"/> Yeast/Mold Culture</p>	<p>AFB/TUBERCULOSIS</p> <p><input type="checkbox"/> Culture</p> <p><input type="checkbox"/> ID isolate</p>	<p>MOLECULAR</p> <p><input type="checkbox"/> Pertussis (Bordetella sp.) PCR</p> <p><input type="checkbox"/> Other: _____ (ERD only)</p>	<p>BRUCELLA</p> <p><input type="checkbox"/> Brucella antibody</p> <p><input type="checkbox"/> CDC referral (attach form 50.34)</p> <p><input type="checkbox"/> HIV-1 antibody</p> <p><input type="checkbox"/> HIV Rapid Test Confirmation</p> <p><input type="checkbox"/> Hepatitis A Diagnosis (IgM Only)</p> <p><input type="checkbox"/> Hepatitis A Immune Status</p> <p><input type="checkbox"/> Hepatitis B Pre-Vaccination</p> <p><input type="checkbox"/> Hepatitis B Prenatal Screen</p> <p><input type="checkbox"/> Hepatitis B Post-Vaccination</p> <p><input type="checkbox"/> Hepatitis B High Risk (Contact to HBV positive)</p> <p><input type="checkbox"/> Hepatitis B High Risk and HCV</p> <p><input type="checkbox"/> Hepatitis C Antibody (Anti-HCV)</p>	<p>HEPATITIS</p> <p><input type="checkbox"/> Hepatitis A,B and C Diagnostic Panel (Acute)</p> <p><input type="checkbox"/> Mumps Immune Status</p> <p><input type="checkbox"/> Plague/Tularemia antibody</p> <p><input type="checkbox"/> Rubella immune status</p> <p><input type="checkbox"/> Rubella diagnosis (call first)</p> <p><input type="checkbox"/> Rubeola immune status</p> <p><input type="checkbox"/> Rubeola diagnosis (call first)</p> <p><input type="checkbox"/> Syphilis Antibody</p> <p><input type="checkbox"/> TB Quantiferon</p> <p><input type="checkbox"/> VZV immune status</p> <p><input type="checkbox"/> Other: _____</p>	<p>VIRUS ISOLATION</p> <p><input type="checkbox"/> Virus Isolation</p> <p>Agent(s) suspected:</p> <p>____ Influenza</p> <p>Rapid Test: Pos____Neg____</p> <p>Not Performed____</p> <p>____ HSV</p> <p>____ Other (Specify): _____</p>	<p>MOLECULAR</p> <p><input type="checkbox"/> Dengue/Chikungunya PCR</p> <p><input type="checkbox"/> Ebola PCR</p> <p><input type="checkbox"/> Other: _____ (ERD only)</p>								
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Phone #: s: General Microbiology (505)383-9126/2728; Molecular Biology (505)383-9130/60; Virology/Serology (505)383-9125/24/33; Switchboard (505)383-9000; Bureau Chief (505)383-9121