



# 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	<b>USER CODES →→</b>	<input checked="" type="checkbox"/> 51000 (Epidemiology)	<input type="checkbox"/> 52325 (PHD: Adult Hepatitis)	<b>Please limit to one code per form</b>
SLD	DATE	<input type="checkbox"/> 52000 (PHD: General)	<input type="checkbox"/> 52330 (PHD: TB Program)	
USE >>>	<<<TIME	<input type="checkbox"/> 52110 (PHD: Prenatal)	<input type="checkbox"/> 51006 (EIP)	
ONLY	STAMP	<input type="checkbox"/> 52120 (PHD: Family Plan)	<input type="checkbox"/> 70704 (OMI)	
		<input type="checkbox"/> 52340 (PHD: Refugee)	<input type="checkbox"/> Other: (Enter Number) <input type="text"/>	

SUBMITTER INFORMATION	PATIENT INFORMATION
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<b>SUBMITTER CODE</b> _____ <b>FACILITY NAME</b> _____ <b>ADDRESS</b> _____ <small>Street or PO</small> City State Zip Code <b>PHONE</b> ( ) _____	<b>PATIENT NAME</b> _____ <small>Last First</small> <b>GENDER</b> <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> TRANSGENDER <b>DATE OF BIRTH</b> MM/ DD/ YYYY : ____/____/____ <b>ADDRESS</b> _____ <small>Street or PO</small> City State Zip Code <b>PATIENT ID (MRN#)</b> _____ <b>SOCIAL SECURITY</b> _____ <b>OTHER ID (HIV#)</b> _____
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<b>CLINICIAN NAME</b> _____ <small>Last First</small> <b>PHONE #</b> ( ) _____	<b>RACE:</b> Check all that apply. <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <b>ETHNICITY:</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
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SPECIMEN INFORMATION
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<b>S</b> <input type="checkbox"/> Abscess <b>P</b> <input type="checkbox"/> Ascites fluid <b>S</b> <input type="checkbox"/> Blood, femoral <b>E</b> <input type="checkbox"/> Blood, heart <b>O</b> <input type="checkbox"/> Blood, plasma <b>C</b> <input type="checkbox"/> Blood, serum <b>U</b> <input type="checkbox"/> Blood, whole <b>I</b> <input type="checkbox"/> Bone <b>R</b> <input type="checkbox"/> Bone marrow <b>M</b> <input type="checkbox"/> Brain <b>C</b> <input type="checkbox"/> Bronchial Biopsy <b>E</b> <input type="checkbox"/> Bronchial Wash <b>O</b> <input type="checkbox"/> Bronchoalveolar lavage <b>U</b> <input type="checkbox"/> Cervix <b>R</b> <input type="checkbox"/> CSF <b>M</b> <input type="checkbox"/> Ear <b>C</b> <input type="checkbox"/> Endocervix <b>E</b> <input type="checkbox"/> Eye <b>E</b> <input type="checkbox"/> Feces/Stool <b>N</b> <input type="checkbox"/> Hair	<b>Fluid (site):</b> _____ Liver Lymph node Lung, left Lung, right Nail (site) _____ Nasopharyngeal swab Nasopharyngeal wash Nasal swab Nasal wash	Oral Fluid Pericardial fluid Peritoneal fluid Pleural fluid Pleural Biopsy Rectum Rectum/Vagina Skin (site) _____ Spleen Sputum, natural	Sputum, nebulized Throat swab Throat wash Tissue (site): _____ Tracheal aspirate Urine Urethra Vagina Wound (site): _____ Other: _____
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<b>SPECIMEN COLLECTION</b> Date/Time Collected ____/____/____ <small>MM/ DD/ YYYY Military Time</small> End of Quantiferon ____/____/____ Incubation (TB Only) MM/ DD/ YYYY Military Time	<b>SPECIMEN TYPE</b> <input type="checkbox"/> Clinical <input type="checkbox"/> Reference	<b>CLINICAL SYMPTOMS</b> <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic: Date of onset: MM / DD / YYYY ____/____/____
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ANALYSIS REQUESTED	For Details: <a href="http://nmhealth.org/publication/view/general/1496/">http://nmhealth.org/publication/view/general/1496/</a>
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<b>BACTERIOLOGY</b> <input type="checkbox"/> B. anthracis <input type="checkbox"/> B. cereus/S. aureus <input type="checkbox"/> Culture, OMI <input type="checkbox"/> Culture, OMI anaerobic <input type="checkbox"/> Campylobacter species: _____ <input type="checkbox"/> E. coli 0157:H7 <input type="checkbox"/> GC culture <input type="checkbox"/> H. influenzae typing <input type="checkbox"/> L. monocytogenes <input type="checkbox"/> Legionella culture <input type="checkbox"/> Necrotizing fasciitis <input type="checkbox"/> N. meningitidis typing <b>ID of Bacteria (specify)</b> <input type="checkbox"/> -Anaerobe _____ <input type="checkbox"/> -Gram negative _____ <input type="checkbox"/> -Gram positive _____ <input type="checkbox"/> <b>EIP isolate (specify)</b> ____ -Group A Streptococcus ____ -Group B Streptococcus ____ -S. pneumoniae	<input type="checkbox"/> Plague FA and culture <input type="checkbox"/> Salmonella, serotype: _____ <input type="checkbox"/> Shigella, serotype: _____ <input type="checkbox"/> Shiga Toxin test/isolation <input type="checkbox"/> Strep, Group B, isolation <input type="checkbox"/> Tularemia culture <input type="checkbox"/> Vibrio <input type="checkbox"/> Yersinia enterocolitica: _____ <input type="checkbox"/> Other: _____	<b>SEROLOGY</b> <input type="checkbox"/> Brucella antibody <input type="checkbox"/> CDC referral (attach form 50.34) <input type="checkbox"/> HIV-1 antibody <input type="checkbox"/> HIV Rapid Test Confirmation <input type="checkbox"/> Hepatitis A Diagnosis (IgM Only) <input type="checkbox"/> Hepatitis A Immune Status <input type="checkbox"/> Hepatitis B Pre-Vaccination <input type="checkbox"/> Hepatitis B Prenatal Screen <input type="checkbox"/> Hepatitis B Post-Vaccination <input type="checkbox"/> Hepatitis B High Risk (Contact to HBV positive) <input type="checkbox"/> Hepatitis B High Risk and HCV <input type="checkbox"/> Hepatitis C Antibody (Anti-HCV)	<input type="checkbox"/> Hepatitis A,B and C Diagnostic Panel (Acute) <input type="checkbox"/> Mumps Immune Status <input type="checkbox"/> Plague/Tularemia antibody <input type="checkbox"/> Rubella immune status <input type="checkbox"/> Rubella diagnosis (call first) <input type="checkbox"/> Rubeola immune status <input type="checkbox"/> Rubeola diagnosis (call first) <input type="checkbox"/> Syphilis Antibody <input type="checkbox"/> TB Quantiferon <input type="checkbox"/> VZV immune status <input checked="" type="checkbox"/> Other: <u>Arbovirus ID</u> <small>(including Zika)</small>	
	<b>MYCOLOGY</b> <input type="checkbox"/> Aerobic actinomycetes <input type="checkbox"/> Coccidioides <input type="checkbox"/> Yeast/Mold Culture		<b>VIRUS LOGY</b> <input type="checkbox"/> <b>Virus Isolation</b> <b>Agent(s) suspected:</b> ____ Influenza Rapid Test: Pos ____ Neg ____ Not Performed ____ ____ HSV ____ Other (Specify): _____	<b>MOLECULAR</b> <input type="checkbox"/> Dengue/Chikungunya PCR <input type="checkbox"/> Ebola PCR <input type="checkbox"/> Other: _____ <small>(ERD only)</small>
	<b>AFB/TUBERCULOSIS</b> <input type="checkbox"/> Culture <input type="checkbox"/> ID isolate			
	<b>MOLECULAR</b> <input type="checkbox"/> Pertussis (Bordetella sp.) PCR <input type="checkbox"/> Other: _____ <small>(ERD only)</small>			

Phone #: (505)383-9126/2728; Molecular Biology (505)383-9130/60; Virology/Serology (505)383-9125/24/33; Switchboard (505)383-9122; Bureau Chief (505)383-9000; Fax (505)383-9121