



# 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 v3.0	<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
SUBMITTER CODE <b>103</b>	PATIENT NAME _____
FACILITY NAME _____	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> TRANSGENDER
ADDRESS _____ Street or PO	DATE OF BIRTH MM/ DD/ YYYY : ____/____/____
City State Zip Code	ADDRESS _____ Street or PO
PHONE ( ) _____	PATIENT ID (MRN#) _____
ATTENTION: _____	SOCIAL SECURITY _____
	OTHER ID (HIV#) _____

CLINICIAN NAME <b>Chad Smelser</b> Last First	PHONE # ( 505 ) 827-0006	<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

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

SPECIMEN COLLECTION	SPECIMEN TYPE	CLINICAL SYMPTOMS
Date/Time Collected ____/____/____ MM/ DD/ YYYY Military Time	<input type="checkbox"/> Clinical	<input type="checkbox"/> Asymptomatic
	<input type="checkbox"/> Reference	<input type="checkbox"/> Symptomatic: Date of onset: MM / DD / YYYY

## ANALYSIS REQUESTED

BACTERIOLOGY		AFB/TUBERCULOSIS/MYCOLOGY		VIRUS ISOLATION		MOLECULAR	
<input type="checkbox"/> B. anthracis	<input type="checkbox"/> N. meningitidis typing	<input type="checkbox"/> Aerobic actinomycetes	<input type="checkbox"/> Arbovirus ID	<input checked="" type="checkbox"/> Virus Isolation	<input type="checkbox"/> Hepatitis A,B and C Diagnostic Panel (Acute)	<input type="checkbox"/> Dengue/Chikungunya PCR	
<input checked="" type="checkbox"/> B. cereus/S. aureus	<input type="checkbox"/> Plague FA and culture	<input type="checkbox"/> AFB Culture	<input type="checkbox"/> CDC referral (attach form 50.34)	Agent(s) suspected:	<input type="checkbox"/> Mumps Immune Status	<input type="checkbox"/> Ebola PCR	
<input type="checkbox"/> Culture, OMI	<input checked="" type="checkbox"/> Salmonella, serotype: _____	<input type="checkbox"/> AFB Reference Isolate	<input type="checkbox"/> HIV Ag/Ab Combo with Reflex	____ Influenza	<input type="checkbox"/> Plague/Tularemia antibody	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Culture, OMI anaerobic	<input checked="" type="checkbox"/> Shigella, serotype: _____	Suspected ID: _____	<input type="checkbox"/> Hepatitis A Diagnosis (IgM Only)	Rapid Test: Pos ____ Neg ____	<input type="checkbox"/> Rubella immune status	(ERD only)	
<input checked="" type="checkbox"/> Campylobacter species: _____	<input checked="" type="checkbox"/> Shiga Toxin test/isolation		<input type="checkbox"/> Hepatitis A Immune Status	Not Performed _____	<input type="checkbox"/> Rubella diagnosis (call first)		
<input type="checkbox"/> E. coli O157:H7	<input type="checkbox"/> Tularemia culture		<input type="checkbox"/> Hepatitis B Pre-Vaccination	____ HSV	<input type="checkbox"/> Rubeola immune status		
<input type="checkbox"/> EIP Group A Streptococcus	<input type="checkbox"/> Vibrio		<input type="checkbox"/> Hepatitis B Prenatal Screen	<input checked="" type="checkbox"/> Other (Specify): <u>norovirus</u>	<input type="checkbox"/> Rubeola diagnosis (call first)		
<input type="checkbox"/> EIP Group B Streptococcus	<input type="checkbox"/> Yersinia enterocolitica: _____		<input type="checkbox"/> Hepatitis B Post-Vaccination		<input type="checkbox"/> SNV Hantavirus		
<input type="checkbox"/> EIP S. pneumoniae isolate	<input checked="" type="checkbox"/> Other: <u>C. Perfringes</u>		<input type="checkbox"/> Hepatitis B Post-Vaccination		<input type="checkbox"/> Syphilis RPR with Reflex to TPPA		
<input type="checkbox"/> GC culture			<input type="checkbox"/> Hepatitis B High Risk		<input type="checkbox"/> Syphilis RPR and TPPA		
<input type="checkbox"/> Haemophilus influenzae typing			<input type="checkbox"/> Hepatitis B High Risk and HCV		<input type="checkbox"/> TB Quantiferon		
<input type="checkbox"/> Listeria monocytogenes			<input type="checkbox"/> Hepatitis C Antibody (Anti-HCV)		<input type="checkbox"/> VZV immune status		
<input type="checkbox"/> Legionella culture			<input type="checkbox"/> Other (Specify): _____				
<b>ID of Bacteria (specify)</b>							
<input type="checkbox"/> Anaerobe _____	<input type="checkbox"/> Fungal/Yeast Culture						
<input type="checkbox"/> Gram negative _____	<input type="checkbox"/> Fungal/Yeast Reference Isolate						
<input type="checkbox"/> Gram positive _____	Suspected ID: _____						
<b>Antimicrobial Resistance</b>							
(Please attach Susceptibility Report)							
<input type="checkbox"/> CRE Panel (Indicate below)	<b>MOLECULAR</b>						
____ CRE:	<input type="checkbox"/> Pertussis (Bordetella sp.) PCR						
____ CRPa (P. aeruginosa)	<input type="checkbox"/> Other: _____						
Other: _____	(ERD only)						

Phone #'s: General Microbiology (505)383-9126/27/28; Molecular Biology (505)383-9130/60; Virology/Serology(505)383-9125/24/33; Specimen Receiving (505)383-9122; SLD Main (505)383-9000; Fax(505)383-9121