



SLD COVID-19 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 116 v1.0 Revised 3/20

USER CODES →

<input checked="" 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) <input type="text"/>

Please limit to one code per form

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

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 _____

Phone Number _____

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"/> Hair	<input type="checkbox"/> Nasal wash	<input type="checkbox"/> Sputum, nebulized
<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
<input type="checkbox"/> Blood, femoral	<input type="checkbox"/> Bronchoalveolar lavage	<input type="checkbox"/> Liver	<input type="checkbox"/> Peritoneal fluid	<input type="checkbox"/> Throat wash
<input type="checkbox"/> Blood, heart	<input type="checkbox"/> Cervix	<input type="checkbox"/> Lymph node	<input type="checkbox"/> Pleural fluid	<input type="checkbox"/> Tissue (site): _____
<input type="checkbox"/> Blood, plasma	<input type="checkbox"/> CSF	<input type="checkbox"/> Lung, left	<input type="checkbox"/> Pleural Biopsy	<input type="checkbox"/> Tracheal aspirate
<input type="checkbox"/> Blood, serum	<input type="checkbox"/> Ear	<input type="checkbox"/> Lung, right	<input type="checkbox"/> Rectum	<input type="checkbox"/> Urine
<input type="checkbox"/> Blood, whole	<input type="checkbox"/> Endocervix	<input type="checkbox"/> Nail (site) _____	<input type="checkbox"/> Rectum/Vagina	<input type="checkbox"/> Urethra
<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: Oropharyngeal Swab

SPECIMEN COLLECTION

Date/Time Collected ____/____/____
MM/ DD/ YYYY Military Time

SPECIMEN TYPE

Clinical

Reference

CLINICAL SYMPTOMS

Asymptomatic

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

ANALYSIS REQUESTED

For Details: <http://nmhealth.org/publication/view/general/1496/>

BACTERIOLOGY

B. anthracis

B. cereus/S. aureus

Culture, OMI

Culture, OMI anaerobic

Campylobacter species: _____

E. coli O157:H7

EIP Group A Streptococcus

EIP Group B Streptococcus

EIP S. pneumoniae isolate

GC culture

Haemophilus influenzae typing

Listeria monocytogenes

Legionella culture

ID of Bacteria (specify)

Anaerobe _____

Gram negative _____

Gram positive _____

Antimicrobial Resistance
 (Please attach Susceptibility Report)

CRE Panel (Indicate below)

____ CRE: _____

____ CRPa (P. aeruginosa)

____ Other: _____

AFB/TUBERCULOSIS/MYCOLOGY

Aerobic actinomycetes

AFB Culture

AFB Reference Isolate

Suspected ID: _____

Fungal/Yeast Culture

Fungal/Yeast Reference Isolate

Suspected ID: _____

MOLECULAR

Pertussis (Bordetella sp.) PCR

Other: _____ (ERD only)

SEROLOGY

Arbovirus ID

CDC referral (attach form 50.34)

HIV Ag/Ab Combo with Reflex

Hepatitis A Diagnosis (IgM Only)

Hepatitis A Immune Status

Hepatitis B Pre-Vaccination

Hepatitis B Prenatal Screen

Hepatitis B Post-Vaccination

Hepatitis B High Risk

Hepatitis B High Risk and HCV

Hepatitis C Antibody (Anti-HCV)

Other (Specify): 2019 Novel Coronavirus _____

Expedite (Provide Reason): _____
 (ERD confirmation will be obtained)

HEPATOLOGY

Hepatitis A, B and C Diagnostic Panel (Acute)

Mumps Immune Status

Rubella immune status

Rubella diagnosis (call first)

Rubeola immune status

Rubeola diagnosis (call first)

SNV Hantavirus

Syphilis RPR with Reflex to TPPA

Syphilis RPR and TPPA

TB Quantiferon

VZV immune status

VIROLOGY

Virus Isolation

Agent(s) suspected:

____ Influenza

Rapid Test: Pos ____ Neg ____

Not Performed _____

____ HSV

____ Other (Specify): _____

MOLECULAR

Dengue/Chikungunya PCR

Ebola PCR

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)383-9068/66 Bureau Chief (505)383-9122; SLD Man (505)383-9121