



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 v4.0 Revised 12/20	USER CODES →	<input checked="" type="checkbox"/> 51000 (Epidemiology)	<input type="checkbox"/> 52325 (PHD: Adult Hepatitis)	Please limit to one code per form
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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SUBMITTER CODE _____ FACILITY NAME _____ ADDRESS _____ <small>Street or PO</small> City State Zip Code PHONE () _____	PATIENT NAME _____ <small>Last First</small> GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> TRANSGENDER DATE OF BIRTH MM/DD/YYYY : ____/____/____ ADDRESS _____ <small>Street or PO</small> City State Zip Code Phone Number _____ PATIENT ID (MRN#) _____ SOCIAL SECURITY _____ OTHER ID (HIV#) _____
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CLINICIAN NAME _____ <small>Last First</small> PHONE # () _____	RACE: 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 ETHNICITY: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
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SPECIMEN INFORMATION

S <input type="checkbox"/> Abscess P <input type="checkbox"/> Ascites fluid E <input type="checkbox"/> Blood, femoral C <input type="checkbox"/> Blood, heart I <input type="checkbox"/> Blood, plasma M <input type="checkbox"/> Blood, serum E <input type="checkbox"/> Blood, whole N <input type="checkbox"/> Bone <input type="checkbox"/> Bone marrow <input type="checkbox"/> Brain	<input type="checkbox"/> Bronchial Biopsy <input type="checkbox"/> Bronchial Wash <input type="checkbox"/> Bronchoalveolar lavage <input type="checkbox"/> Cervix <input type="checkbox"/> CSF <input type="checkbox"/> Ear <input type="checkbox"/> Endocervix <input type="checkbox"/> Eye <input type="checkbox"/> Feces/Stool <input type="checkbox"/> Genital	<input type="checkbox"/> Hair <input type="checkbox"/> Fluid (site): _____ <input type="checkbox"/> Liver <input type="checkbox"/> Lymph node <input type="checkbox"/> Lung, left <input type="checkbox"/> Lung, right <input type="checkbox"/> Nail (site): _____ <input type="checkbox"/> Nasopharyngeal swab <input type="checkbox"/> Nasopharyngeal wash <input type="checkbox"/> Nasal swab	<input type="checkbox"/> Nasal wash <input type="checkbox"/> Pericardial fluid <input type="checkbox"/> Peritoneal fluid <input type="checkbox"/> Pleural fluid <input type="checkbox"/> Pleural Biopsy <input type="checkbox"/> Rectum <input type="checkbox"/> Rectum/Vagina <input type="checkbox"/> Skin (site): _____ <input type="checkbox"/> Spleen <input type="checkbox"/> Sputum, natural	<input type="checkbox"/> Sputum, nebulized <input type="checkbox"/> Throat swab <input type="checkbox"/> Throat wash <input type="checkbox"/> Tissue (site): _____ <input type="checkbox"/> Tracheal aspirate <input type="checkbox"/> Urine <input type="checkbox"/> Urethra <input type="checkbox"/> Vagina <input type="checkbox"/> Wound (site): _____ <input type="checkbox"/> Other: _____
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SPECIMEN COLLECTION Date/Time Collected ____/____/____ <small>MM/DD/YYYY Military Time</small>	SPECIMEN TYPE <input type="checkbox"/> Clinical <input type="checkbox"/> Reference	CLINICAL SYMPTOMS <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic: Date of onset: MM/DD/YYYY ____/____/____
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ANALYSIS REQUESTED	For Details: http://nmhealth.org/publication/view/general/1496/
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BACTERIOLOGY <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"/> EIP Group A Streptococcus <input type="checkbox"/> EIP Group B Streptococcus <input type="checkbox"/> EIP S. pneumoniae isolate <input type="checkbox"/> GC culture <input type="checkbox"/> Haemophilus influenzae typing <input type="checkbox"/> Listeria monocytogenes <input type="checkbox"/> Legionella culture ID of Bacteria (specify) <input type="checkbox"/> Anaerobe _____ <input type="checkbox"/> Gram negative _____ <input type="checkbox"/> Gram positive _____ Antimicrobial Resistance (Please attach Susceptibility Report) <input type="checkbox"/> CRE Panel (Indicate below) _____ CRE: _____ _____ CRPa (P. aeruginosa) _____ Other: _____	<input type="checkbox"/> N. meningitidis typing <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"/> Tularemia culture <input type="checkbox"/> Vibrio <input type="checkbox"/> Yersinia enterocolitica: _____ <input type="checkbox"/> Other: _____ AFB/TUBERCULOSIS/MYCOLOGY <input type="checkbox"/> Aerobic actinomycetes <input type="checkbox"/> AFB Culture <input type="checkbox"/> AFB Reference Isolate Suspected ID: _____ <input type="checkbox"/> Fungal/Yeast Culture <input type="checkbox"/> Fungal/Yeast Reference Isolate Suspected ID: _____ MOLECULAR <input type="checkbox"/> Pertussis (Bordetella sp.) PCR <input type="checkbox"/> Other: _____ (ERD only)	SEROLOGY <input type="checkbox"/> Arbovirus ID <input type="checkbox"/> CDC referral (attach form 50.34) <input type="checkbox"/> HIV Ag/Ab Combo with Reflex <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 <input type="checkbox"/> Hepatitis B High Risk and HCV <input type="checkbox"/> Hepatitis C Antibody (Anti-HCV) <input type="checkbox"/> Other (Specify): _____ VIROLOGY <input type="checkbox"/> 2019 Novel Coronavirus RT-PCR <input checked="" type="checkbox"/> Influenza RT-PCR (Per Epidemiology Guidance) <input type="checkbox"/> Hospitalized Rapid Test: Pos____Neg____ Not Performed____ <input type="checkbox"/> Dengue/Chikungunya PCR <input type="checkbox"/> Ebola PCR <input type="checkbox"/> Other: _____ (ERD only)
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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; Specimen Receiving (505)383-9088/66 Bureau Chief (505)383-9122; SLD Main (505)383-9000; Fax (505)383-9121