Vermont Department of Health Laboratory - Clinical Test Request Form

VERMONT DEPARTMENT OF HEALTH

Mailing Address: PO Box 1125, Burlington, VT 05402-1125
Physical Address: 359 South Park Drive, Colchester VT 05446 ● (802) 338-4724 / (800) 660-9997 in VT only

A separate form is required for each specimen. All specimens must be labeled with patient name and date of collection.

Specimen Information	For Laboratory Use Only
Date of Collection:_____ Date of Onset:_____ Time of Collection:_____ ICD Code: _____	LIMS # Date Received:

Clinical Lab/Practice Information			Patient Information		
Clinical Laboratory/ Practice Name **Northwestern Medical Center**			Last Name	First Name	
Address **133 Fairfield St**			Address		
City/Town **St. Albans**	State **VT**	Zip code **05478**	City/Town	State	Zip code
Telephone Number **802-524-1070**	Fax Number (for a faxed result) **802-524-1098**		MRN# or ID#	Specimen ID#	
Referring Physician Last Name/first Name **Suppan, Thomas MD**			Date of Birth (MM/DD/YYYY)		
NPI # **1386679678**			Gender ☐ Male ☐ Female ☐ Choose Not to Disclose		
Comments			☐ Gender Identity (please specify): _____		

☐ Check if No Insurance	Billing Information – Attach Copy of Insurance Card	
Responsible Party Name	Medicaid Number	Medicare Number
Insurance Company Name	ID Number	Group Number
Subscriber Name	Relationship	
Secondary Insurance Company Name	ID Number	Group Number
Subscriber Name	Relationship	

Specimen Source

☐ Aspirate site:_____	☐ Fluid-site:_____	☐ Sputum
☐ Biopsy tissue site:_____	☐ Isolate-source:_____	☐ Stool
☐ Blood, Venous	☐ Lymph Node	☐ Swab
☐ Bone	☐ Nasal Swab	☐ Urine
☐ Bronchial Wash	☐ Nasopharyngeal Swab	☐ Other:
☐ Bronchoalveolar Brush	☐ Nasal Wash	
☐ Bronchoalveolar Lavage	☐ Oral Mucosal Transudate (Oral Fluid)	
☐ Cerebral Spinal Fluid	☐ Serum: ☐ Acute ☐ Convalescent	

Specimen Site

☐ Cervix	☐ Perianal
☐ Endocervix	☐ Rectal
☐ Lung	☐ Throat
☐ Nasal Mucosa	☐ Urethra
☐ Nasopharynx	☐ Vaginal
☐ Oral	☐ Other:

Reason for Test

☐ Confirmation/Reference	☐ Immune Status
☐ Contact/Exposure	☐ Outbreak:
☐ Diagnostic	Facility Name: _____
☐ Hospitalized	☐ Pregnancy
☐ Immigrant/Refugee	☐ Screen
☐ VDHL Request	☐ Symptomatic

For Laboratory Use Only

☐ Transport medium expired ☐ Duplicate of # _____ ☐ Overfilled ☐ QNS/Leaked in Transit ☐ Too Old to Test

☐ Other:_____ Shipping Temperature upon arrival: ☐ Cold ☐ Room Temp.

Epidemiology notified of receipt of isolate:_____ Result:_____

Epidemiology notified of preliminary results:_____ Provider notified of preliminary results:_____

Epidemiology notified of final results: _____ Provider notified of final results:_____

Laboratory Examination Requested

Bacteriology

- ☐ Enteric screen (Salmonella, Shigella, E. coli (STEC), Campylobacter, Yersinia, Vibrio)
- ☐ Gonorrhea/Chlamydia PCR
- ☐ Pertussis species Culture
- ☐ Pertussis Culture/PCR (B. pertussis, B. parapertussis, B. holmseii)
- ☐ Isolate for Identification:
- X☐ Other: **COVID-19**

Biothreat Agents (Call VDHL Prior to Sending)

- ☐ Bacillus anthracis
- ☐ Brucella
- ☐ Francisella tularensis
- ☐ Yersinia pestis
- ☐ Other:
- ☐ Burkholderia
- ☐ Coxiella burnettii
- ☐ Smallpox

Specimens/Isolates sent per VDH Requirement

If the specimen being submitting is from a CIDT (Culture Independent Diagnostic Test), please use this section

- ☐ Arboviruses (list name): _____
- ☐ Campylobacter
- ☐ Candida auris
- ☐ Carbapenem-resistant Acinetobacter baumannii (CRAB)*
- ☐ Carbapenem-resistant Enterobacteriaceae (CRE)*
- ☐ Carbapenem Resistant Pseudomonas aeruginosa (CRPA)*
- ☐ E. coli (STEC)
- ☐ Haemophilus influenza typing (Isolated from sterile site)
- ☐ Influenza (novel strains only)
- ☐ Leptospira species
- ☐ Listeria monocytogenes
- ☐ Mycobacterium tuberculosis complex
- ☐ Neisseria meningitidis (isolated from sterile site)
- ☐ Salmonella
- ☐ Shigella
- ☐ Vibrio
- ☐ Other:

Mycobacteriology

- ☐ Mycobacterial Culture/Smear
- ☐ Mycobacterial/Fungal Culture
- ☐ NAAT for Direct Detection of MTB in specimen
- ☐ Isolate for Identification: _____
- ☐ Other:

Comments:

Parasitology

- ☐ Cryptosporidium EIA
- ☐ Giardia EIA
- ☐ Ova and Parasites (O & P)
- ☐ Acid Fast Stain for Cyclospora
- ☐ Pinworm
- ☐ Worm for Identification
- ☐ Other:

Serology

- ☐ Brucella Total Antibody
- ☐ Dengue IgM
- ☐ Francisella Total Antibody
- ☐ Hepatitis B Panel (Surface Antigen, Surface Antibody, Core Total Antibody)
- ☐ Hepatitis B Surface Antigen
- ☐ Hepatitis B Core Total Antibody
- ☐ Hepatitis B Surface Antibody (for Vaccine Response)
- ☐ Hepatitis C Antibody Screen
- ☐ HIV-1/HIV-2 Antibody and p24 Antigen EIA (serum)
- ☐ HIV-1 Oral Fluid
- ☐ Interferon Gamma Release Assay (IGRA) Quantiferon TB Gold Plus
  Tubes incubated at 37˚C: ☐ NO
  ☐ YES Date/Time: _____
- ☐ Legionella pneumophila Antigen (urine)
- ☐ Measles IgG
- ☐ Measles IgM**
- ☐ Mumps IgG
- ☐ Rubella IgG
- ☐ Rubella IgM**
- ☐ Syphilis - RPR Screen with reflex to RPR Titer and FTA
- ☐ Syphilis - FTA-ABS confirmation (includes RPR Titer)
- ☐ Syphilis - VDRL (Cerebral Spinal Fluid Only)
- ☐ Varicella zoster IgG
- ☐ Zika IgM
- ☐ Other:

Toxicology

- ☐ Other:

Molecular Virology

- ☐ Arbovirus PCR (Dengue, Chikungunya, Zika)
- ☐ Influenza A & B PCR:
  Date Vaccinated: _____
  Foreign travel within 10 days of illness onset: ☐ YES ☐ NO
  Location of travel:
- ☐ Measles PCR**
- ☐ Mumps PCR**
- ☐ Norovirus PCR
- ☐ Other:

* Please include copy of Antimicrobial Susceptibility test results.
** Please notify the Epidemiology Unit with any suspect Measles, Mumps, or Rubella cases by calling 802-863-7240 or 1-800-640-4374.