OFFICE OF LABORATORY SERVICES
167 11th Avenue | South Charleston, WV 25303
PH: (304) 558-3530 | FX: (304) 558-2006

PLACE BARCODE HERE

OLS USE ONLY

MICROBIOLOGY LABORATORY SPECIMEN SUBMISSION FORM

PATIENT INFORMATION

PATIENT ID (Chart #, etc.) *MAX. 17 CHARACTERS*		
LAST NAME	FIRST NAME	MI
DATE OF BIRTH	SS# *(last 4 only, optional)*	
COUNTY OF RESIDENCE	SEX ❑ Female ❑ Male	
STREET ADDRESS		
CITY	STATE	ZIP
PATIENT PHONE NO. *(optional)*		

SUBMITTER INFORMATION

FACILITY NAME		
MAILING ADDRESS		
CITY	STATE	ZIP
COUNTY		
ATTENTION TO		
PHONE NO.		
FAX NO.		

COMMENTS:

DATE OF COLLECTION:

SITE/SOURCE OF SPECIMEN:

❑ Blood	❑ Sputum
❑ Cellulose tape mount	❑ Sputum, induced
❑ CSF	❑ Stool
❑ Nasopharyngeal	❑ Stool, bloody
❑ Rectal	❑ Throat
❑ Serum	❑ Urethra
❑ Serum, acute	❑ Urine

- ❑ Serum, convalescent
- ❑ Wound Location:
- ❑ Bronchial Specify:
- ❑ Tissue Specify:
- ❑ Fluid Specify:
- ❑ Other Specify:

TEST(S) REQUESTED:

BACTERIOLOGY

- ❑ Referred Culture
- ❑ Pertussis culture / PCR
- ❑ Enteric (stool in Cary-Blair)
- ❑ Gonorrhea culture/smear
- ❑ Unknown bacteriology ID

Suspected Organism (s):

VIROLOGY

- ❑ Influenza RT-PCR
  - Submitted for:
  - ❑ Surveillance (Sentinel)
  - ❑ Other *(note in Comments)*
  - ❑ Outbreak
    - If outbreak . . .
    - ❑ School
    - ❑ Nursing Home/LTCF
    - ❑ Other
- ❑ Respiratory Pathogen Panel ***

Was specimen pre-screened for presence of Influenza? ❑ Yes ❑ No

- ❑ Norovirus RT-PCR ***
- ❑ GI Pathogen Panel ***

MYCOBACTERIOLOGY

- ❑ Culture/Smear C
- ❑ TB ID/Confirmation R
- ❑ MOTT Identification R

Suspected Organism:

Date growth appeared:

Patient taking TB drugs?
❑ Yes ❑ No
Date Started:

Skin Test
❑ POS (+) ❑ NEG (-)

Chest X-ray
❑ Abnormal ❑ Normal

Contact to TB patient?
❑ Yes ❑ No

Refrigerated? ❑ Yes ❑ No

PARASITOLOGY

- ❑ Fecal Parasite Exam (10% formalin)
- ❑ Pinworm Exam (cellulose tape mount)

SENDOUT

- ❑ Referred Culture/ID

OLS USE ONLY	
❑ UNSAT | Reason:	ACC:
❑ UNRELIABLE | Reason:	DE:
❑ SATISFACTORY	CKD:

OUTBREAK NUMBER
(REQUIRED FOR OUTBREAKS - OBTAIN FROM DIDE)

CONTACT NAME: _____

****** Testing performed on outbreak specimens ONLY.***

DIDE = Division of Infectious Disease Epi

FAILURE TO COMPLETE THIS FORM IN ITS ENTIRETY MAY RESULT IN DELAYED TEST RESULTS