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 #, MRN, etc.) *MAX. 17 CHARACTERS*

LAST NAME	FIRST NAME	MI

DATE OF BIRTH | SS# *(last 4 only, optional)*

RACE
❑ White ❑ Asian ❑ Black ❑ Other
❑ American Indian/Alaskan
❑ Native Hawaiian or other Pacific Islander

ETHNICITY
❑ Not Hispanic or Latino
❑ Hispanic or Latino
❑ Unknown

COUNTY OF RESIDENCE | SEX (at birth) ❑ Female ❑ Male

STREET ADDRESS

CITY	STATE	ZIP

PATIENT PHONE NO. *(optional)*

SUBMITTER INFORMATION

THE INFORMATION BELOW IS FOR THE MAILING OR FAXING OF TEST REPORTS PLEASE MAKE SURE THE MAILING ADDRESS AND FAX NUMBER ARE ACCURATE

FACILITY NAME

MAILING ADDRESS (*NO PO BOX NUMBERS*)

CITY	STATE	ZIP

COUNTY

ATTENTION TO

PHONE NO.

FAX NO.

COMMENTS:

DATE OF COLLECTION:

SITE/SOURCE OF SPECIMEN:

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

❑ 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
❑ Unknown bacterial ID
Suspected Organism (s):

MOLECULAR

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

RESPIRATORY PATHOGENS
❑ Respiratory Pathogen Panel ***
❑ Influenza RT-PCR
Submitted For:
❑ Surveillance ❑ Outbreak
❑ Unsubtypeable Influenza A

Optional Respiratory Specimen Data
Symptom Onset Date: / /
Patient Level of Care:
❑ Inpatient ❑ Outpatient
Was specimen pre-screened?
❑ Yes (specify under Comments)
❑ No

MYCOBACTERIOLOGY
❑ Culture / Smear C
❑ TB ID / Confirmation R
❑ NTM 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
❑ Referral Testing / ID

REFERENCE
❑ ARLN Reference DST

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

DIDE = Division of Infectious Disease Epi

OLS USE ONLY

❑ UNSAT | Reason:
❑ UNRELIABLE | Reason:
❑ SATISFACTORY

ACC:
DE:
CKD:

OUTBREAK NUMBER
(REQUIRED FOR OUTBREAKS - OBTAIN FROM DIDE)

CONTACT NAME:

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