

**OFFICE OF LABORATORY SERVICES**

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PLACE BARCODE HERE  
 OLS USE ONLY

**MICROBIOLOGY LABORATORY SPECIMEN SUBMISSION FORM****PATIENT INFORMATION**

PATIENT ID (Chart #, etc.)		
LAST NAME	FIRST NAME	MI
DATE OF BIRTH	SS# (last 4 only, optional)	
COUNTY OF RESIDENCE	SEX <input type="checkbox"/> Female <input type="checkbox"/> Male	
STREET ADDRESS		
CITY	STATE	ZIP
PATIENT PHONE NO. (optional)		

<b>DATE OF COLLECTION:</b>	
<b>SITE/SOURCE OF SPECIMEN:</b>	
<input type="checkbox"/> Blood	<input type="checkbox"/> Sputum
<input type="checkbox"/> Cellulose tape mount	<input type="checkbox"/> Sputum, induced
<input type="checkbox"/> CSF	<input type="checkbox"/> Stool
<input type="checkbox"/> Nasopharyngeal	<input type="checkbox"/> Stool, bloody
<input type="checkbox"/> Rectal	<input type="checkbox"/> Throat
<input type="checkbox"/> Serum	<input type="checkbox"/> Urethra
<input type="checkbox"/> Serum, acute	<input type="checkbox"/> Urine
<input type="checkbox"/> Serum, convalescent	
<input type="checkbox"/> Wound ( <i>location</i> : _____ )	
<input type="checkbox"/> Bronchial ( <i>specify</i> : _____ )	
<input type="checkbox"/> Tissue ( <i>specify</i> : _____ )	
<input type="checkbox"/> Fluid ( <i>specify</i> : _____ )	
<input type="checkbox"/> Other ( <i>specify</i> : _____ )	

**SUBMITTER INFORMATION**

SUBMITTER NAME		
STREET ADDRESS		
CITY	STATE	ZIP
COUNTY		
ATTENTION TO:		
PHONE NO.		
FAX NO.		

<b>TEST(S) REQUESTED:</b>	
<b>BACTERIOLOGY</b>	<b>MYCOBACTERIOLOGY</b>
<input type="checkbox"/> General/Referred Culture	<input type="checkbox"/> Culture/Smear <span style="float: right;">C</span>
<input type="checkbox"/> Pertussis culture	<input type="checkbox"/> TB ID/Confirmation <span style="float: right;">R</span>
<input type="checkbox"/> Enteric (stool culture)	<input type="checkbox"/> MOTT Identification <span style="float: right;">R</span>
<input type="checkbox"/> Gonorrhea culture	Suspected Organism:
<input type="checkbox"/> Gonorrhea smear	Patient taking TB drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Unknown bacteriology ID	Date growth appeared:
Suspected Organism:	Refrigerated? <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>VIROLOGY ISOLATION</b>
<input type="checkbox"/> Respiratory virus panel <i>(inc. culture for Influenza, Adenovirus, Parainfluenza, and RSV)</i>
<input type="checkbox"/> Influenza A subtyping

<b>PARASITOLOGY</b>
<input type="checkbox"/> O&P, 10% formalin
<input type="checkbox"/> O&P, PVA
<input type="checkbox"/> O&P, other (inc. pinworm)

<b>ARBOVIRUS</b>
<input type="checkbox"/> Arbovirus antibody, human

<b>MOLECULAR</b>
<input type="checkbox"/> Norovirus RT-PCR
----- <b>ONLY AFTER IDEP CONSULTATION</b> EPI CONTACT NAME:

<b>MANDATORY ARBOVIRUS INFORMATION</b>
Date of Symptom Onset:
Clinical Symptoms:
CSF Information  Total WBC: Total Protein:

<b>MANDATORY VIROLOGY ISOLATION INFORMATION</b>
Travel History (Date/Location):
Date of Symptom Onset:
Animal Contact ? <input type="checkbox"/> Yes <input type="checkbox"/> No   Avian Contact ? <input type="checkbox"/> Yes <input type="checkbox"/> No
Received current vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No
Vaccine Location: _____ Within last 3 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>OLS USE ONLY</b>	<input type="checkbox"/> SATISFACTORY	ACC:
<input type="checkbox"/> UNSAT   Reason/ID:		DE:
<input type="checkbox"/> UNRELIABLE   Reason/ID:		CKD:

Comments: