

**BACTERIOLOGY / BIOTERRORISM / MOLECULAR DIAGNOSTICS / TB TEST REQUEST FORM**

**STATE OF UTAH PUBLIC HEALTH LABORATORIES**  
 46 NORTH MEDICAL DRIVE  
 SALT LAKE CITY, UTAH 84113-1105  
 TELEPHONE: (801) 584-8400 FAX: (801) 584-8486  
 http://health.utah.gov/lab/microbiology

**FOR LABORATORY USE ONLY**

LAB#:  
 \_\_\_\_\_  
 DATE STAMP:  
 \_\_\_\_\_

**TESTING WILL NOT BE PERFORMED UNLESS SLIP IS COMPLETELY FILLED OUT. PLEASE PRINT CLEARLY FOR ACCURACY.**

**PATIENT INFORMATION:**

Patient Name (Last, First):

Patient ID #:	DATE OF BIRTH (mm/dd/yy) ____/____/____	AGE:	SEX: M      F
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**PROVIDER INFORMATION:**

Provider Code:

Physician: \_\_\_\_\_  
 Provider Phone: \_\_\_\_\_  
 Provider Email: \_\_\_\_\_  
 Secure Fax #: \_\_\_\_\_

**SPECIMEN  
 COLLECTION DATE**  
 (mm/dd/yy)  
 \_\_\_\_/\_\_\_\_/\_\_\_\_

**SPECIMEN SOURCE/SITE:**

- |   |  |
|---|--|
| <input type="checkbox"/> Blood  | <input type="checkbox"/> Skin                                |
| <input type="checkbox"/> Bronchial Wash                                   | <input type="checkbox"/> Sputum (specify: natural / induced) |
| <input type="checkbox"/> Cerebrospinal Fluid (CSF)                        | <input type="checkbox"/> Swab (specify): _____               |
| <input type="checkbox"/> Cervix   | <input type="checkbox"/> Stool                               |
| <input type="checkbox"/> Environmental (specify): _____                   | <input type="checkbox"/> Throat                              |
| <input type="checkbox"/> Fluid (specify): _____                           | <input type="checkbox"/> Tissue (specify): _____             |
| <input type="checkbox"/> Food (specify): _____                            | <input type="checkbox"/> Urethra                             |
| <input type="checkbox"/> Isolate (source): _____                          | <input type="checkbox"/> Urine                               |
| <input type="checkbox"/> Lesion   | <input type="checkbox"/> Vagina                              |
| <input type="checkbox"/> Nasopharyngeal (specify: swab / wash / aspirate) | <input type="checkbox"/> Vomitus                             |
| <input type="checkbox"/> Scab   | <input type="checkbox"/> Wound/Abscess                       |
| <input type="checkbox"/> Serum  | <input type="checkbox"/> Other (specify): _____              |

**STATE OF ORIGIN  
 OF  
 PATIENT / SAMPLE**

**BACTERIOLOGY / TB TESTS:**

- Bacterial Culture
- Bacterial ID / Referral
- Cryptosporidium
- Giardia
- Mycobacterial Culture
- Mycobacterial ID / Referral
- Other (specify): \_\_\_\_\_

**BIOTERRORISM TESTS (include Chain of Custody Form, If Applicable):**

- |   |  |
|---|--|
| <input type="checkbox"/> Bacillus anthracis     | <input type="checkbox"/> Brucella spp. Microagglutination            |
| <input type="checkbox"/> Burkholderia spp.      | <input type="checkbox"/> Francisella tularensis Microagglutination   |
| <input type="checkbox"/> Brucella spp.          | <input type="checkbox"/> Yersinia pestis Hemagglutination            |
| <input type="checkbox"/> Coxiella burnetii      | <input type="checkbox"/> Clostridium botulinum culture & toxin       |
| <input type="checkbox"/> Francisella tularensis | <input type="checkbox"/> Ricin toxin (non-clinical)                  |
| <input type="checkbox"/> Orthopox virus         | <input type="checkbox"/> Staphylococcus Enterotoxin B (non-clinical) |
| <input type="checkbox"/> Vaccinia virus         | <input type="checkbox"/> BDS Testing                                 |
| <input type="checkbox"/> Varicella zoster virus |  |
| <input type="checkbox"/> Variola virus          |  |
| <input type="checkbox"/> Yersinia pestis        |  |
| <input type="checkbox"/> Multiagent Screen      | <input type="checkbox"/> Other (specify): _____                      |

**MOLECULAR TESTS:**

- Bordetella pertussis PCR
- Influenza A & B Virus PCR (NO H subtyping)
- Influenza A & B Virus PCR (with H subtyping)
- Norovirus PCR
- SARS PCR
- St. Louis Encephalitis Virus PCR
- West Nile Virus PCR
- Western Equine Encephalitis PCR
- Human West Nile Virus IgM
- Other (specify): \_\_\_\_\_

**ADDITIONAL INFORMATION**

(List pertinent information including presumptive ID)