Vermont Department of Health Laboratory - Clinical Test Request Form

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: | | | LIMS # Date Received: | | | | |
| Time of Collection: | of Collection: ICD Code: | | | | | | |
| Clinical Lab/Practice Information | | | Patient Information | | | | |
| Clinical Laboratory/ Practice Name | | | Last Name | | First Name | | |
| Address | | | Address | | | | |
| City/Town | State | Zip code | City/Town | | State | Zip code | |
| Telephone Number | hone Number Fax Number (for a faxed result) | | | | Specimen ID# | | |
| Referring Physician Last Name/first Name | Date of Birth (MM/DD/YYYY) | (MM/DD/YYYY) | | | | | |
| NPI# | Gender ☐ Male ☐ Female ☐ Other | | | | | | |
| Comments: (specimen site ca | Race | | | | | | |
| Specimen site section) | ☐ African American or Black ☐ American Indian or Alaska Native ☐ Asian ☐ Multiracial ☐ Pacific Islander ☐ White ☐ Unknown ☐ Other | | | | | | |
| | Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Other | | | | | | |
| | | | | | | | |
| Check if no insurance Responsible Party Name | ыші | iiiioiiiialioii – | Medicaid Number | e Card | Medicare Nur | mber | |
| Insurance Company Name | | | ID Number | | Group Number | | |
| Subscriber Name | | | Relationship | | | | |
| | | | | | | | |
| | | | imen Source | | | | |
| Aspirate site: Biopsy tissue site: | | | | | | | |
| Blood, Venous | | lsolate-s | | | | | |
| □ Blood, verious □ Lymph 1 | | | = | | | | |
| ☐ Bronchial Wash | | | aryngeal Swab | | | | |
| Bronchoalveolar Brush | | ☐ Nasai W | _ | | | | |
| | | | cosal Transudate (Oral Fluid) | | | | |
| Cerebral Spinal Fluid | | ☐ Serum: | ☐ Acute ☐ Convalescent | | | | |
| Specimen Site | | | Reason for Test | | | | |
| ☐ Cervix ☐ Perianal | | | ☐ Confirmation/Reference ☐ Immune Status | | | | |
| Endocervix | Rectal | | Contact/Exposure | | utbreak: | | |
| Lung | ☐ Throat | | Diagnostic | Facility Name: | | | |
| | Nasal Mucosa Urethra | | Hospitalized | | ☐ Pregnancy ☐ Screen | | |
| ☐ Nasopharynx ☐ Vaginal ☐ Oral ☐ Other: | | ☐ Immigrant/Refugee☐ VDHL Request | _ | creen Symptomatic | | | |
| ☐ Oral | △ Other. | | | | припаис | | |
| For Laboratory Use Only | | | | | | | |
| ☐ Transport medium expired | ☐ Duplicate | of # | | | | | |
| Other: | Shipping Temperature upon arrival: Cold Room Temp. | | | | | | |
| VDH EPI notified of receipt of isolate: | | | Result: | | | | |
| VDH EPI notified of preliminary results: | | | Provider notified of preliminary results: | | | | |
| VDH EPI notified of final results: | | | Provider notified of final results: | | | | |
| | | | | | | | |

PLEASE COMPLETE BACK SIDE

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| Bacteriology | Serology | | | | |
|--|--|--|--|--|--|
| ☐ Enteric screen (Salmonella, Shigella, E. coli (STEC), Campylobacter, Yersinia, Vibrio) | ☐ Brucella Total Antibody ☐ Francisella Total Antibody | | | | |
| ☐ Gonorrhea/Chlamydia PCR | ☐ Dengue IgM | | | | |
| ☐ Pertussis species Culture | ☐ Hepatitis B Panel (Surface Antigen, Surface Antibody, Core Total Antibody) | | | | |
| ☐ Pertussis Culture/PCR (B. pertussis, B. parapertussis, B. holmseii) | ☐ Hepatitis B Surface Antigen | | | | |
| ☐ Isolate for Identification: | ☐ Hepatitis B Surface Antigen | | | | |
| □ Other: | ☐ Hepatitis B Core Total Antibody | | | | |
| Parasitology | ☐ Hepatitis B Surface Antibody (for Vaccine Response) | | | | |
| ☐ Cryptosporidium EIA ☐ Giardia EIA | ☐ Hepatitis C Antibody Screen | | | | |
| ☐ Ova and Parasites (O & P) ☐ Acid Fast Stain for Cyclospora | ☐ HIV-1/HIV-2 Antibody and p24 Antigen EIA (serum) | | | | |
| □ Pinworm | ☐ HIV-1 Oral Fluid | | | | |
| ☐ Worm for Identification | ☐ Interferon Gamma Release Assay (IGRA) Quantiferon TB Gold Plus | | | | |
| ☐ Other: | Tubes incubated at 37°C: □ NO | | | | |
| Biothreat Agents (Call VDHL Prior to Sending) | ☐ YES Date/Time: | | | | |
| ☐ Bacillus anthracis ☐ Burkholderia | ☐ Legionella pneumophila Antigen (urine) | | | | |
| ☐ Brucella ☐ Coxiella burnettii | ☐ Measles IgG ☐ Measles IgM** | | | | |
| ☐ Francisella tularensis ☐ Smallpox | ☐ Mumps IgG | | | | |
| ☐ Yersinia pestis | ☐ Rubella IgG ☐ Rubella IgM** | | | | |
| ☐ Other: | ☐ Syphilis - RPR Screen with reflex to RPR Titer and FTA | | | | |
| Specimens/Isolates sent per VDH Requirement | ☐ Syphilis - FTA-ABS confirmation (includes RPR Titer) | | | | |
| If the specimen being submitting is from a CIDT (Culture | ☐ Syphilis - VDRL (Cerebral Spinal Fluid Only) | | | | |
| Independent Diagnostic Test), please use this section | ☐ Varicella zoster IgG | | | | |
| Arboviruses (list name): | ☐ Zika IgM | | | | |
| ☐ Campylobacter | Other: | | | | |
| ☐ Candida auris | Molecular Virology | | | | |
| ☐ Carbapenem-resistant Acinetobacter baumannii (CRAB)* | ☐ Arbovirus PCR (Dengue, Chikungunya, Zika) | | | | |
| ☐ Carbapenem-resistant Enterobacteriaceae (CRE)* | ☐ Influenza A & B PCR: | | | | |
| ☐ Carbapenem Resistant Pseudomonas aeruginosa (CRPA)* | Date Vaccinated: | | | | |
| ☐ E. coli (STEC) | Foreign travel within 10 days of illness onset: YES NO | | | | |
| ☐ Haemophilus influenza typing (Isolated from sterile site) | Location of travel: | | | | |
| ☐ Influenza (novel strains only) | ☐ Measles PCR** ☐ Mumps PCR** | | | | |
| ☐ Leptospira species☐ Listeria monocytogenes | □ Norovirus PCR | | | | |
| ☐ Mycobacterium tuberculosis complex | ☐ SARS-CoV-2 (Coronavirus 2019-nCoV) | | | | |
| □ Neisseria meningitidis (isolated from sterile site) | X Other: NVO | | | | |
| □ Salmonella | | | | | |
| □ Shigella | Additional COVID-19 Questions | | | | |
| □ Vibrio | Event name: | | | | |
| □ Other: | First Test? ☐ Yes ☐ No ☐ Unknown | | | | |
| Mycobacteriology | Employed in Healthcare? ☐ Yes ☐ No ☐ Unknown | | | | |
| ☐ Mycobacterial Culture/Smear | Symptomatic as defined by CDC? ☐ Yes ☐ No ☐ Unknown | | | | |
| ☐ Mycobacterial/Fungal Culture | If Yes, Date of Onset: | | | | |
| ☐ NAAT for Direct Detection of MTB in specimen | Hospitalized? ☐ Yes ☐ No ☐ Unknown | | | | |
| ☐ Isolate for Identification: | ICU? ☐ Yes ☐ No ☐ Unknown | | | | |
| ☐ Other: | Congregate care resident? | | | | |
| | Pregnant? ☐ Yes ☐ No ☐ Unknown | | | | |
| | | | | | |

^{*} 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.