



Point of Contact
at the clinic/lab

Patient Information			Requesting Submitter Information		
Name: Last First Middle			Facility Name:		Facility Contact:
Date of Birth: MM/DD/YYYY			Street Address:		
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			City/State: # for Point of Contact		Number where results will be faxed
Unique ID (MRN, Outbreak#, etc.):			Phone:		Fax:
Specimen Source (Nasal, tissue, intravenous, etc) [if applicable] :			Provider Name (If different from above):		Doctor providing patient care
Date Sample Collected			Provider NPI / CLIA#:		
Collection Date:			Time: am pm		

Select intravenous for serum

Choose one type only per
Test Requisition form:
Urine or Serum

Choose if Exposure is less
than 6 weeks

Choose if Exposure is
greater than 6 weeks

Specimen Type		Microbiology		Molecular Diagnostics	
		Referred Isolate ID		Arboviruses	
<input type="checkbox"/>	Blood culture bottle (aerobic)	<input type="checkbox"/>	<i>Streptococcus pneumoniae</i> [Culture]	<input type="checkbox"/>	Zika Virus Panel [PCR/IgM]
<input type="checkbox"/>	Blood culture bottle (anaerobic)	<input type="checkbox"/>	Group B <i>Streptococcus</i> (GBS) [Culture]		
<input type="checkbox"/>	Whole Blood		<i>Listeria spp.</i> (all species) [Culture]		
<input type="checkbox"/>	Serum		<i>Salmonella spp.</i> (all species) [Culture]		
<input type="checkbox"/>	Plasma		<i>Shigella spp.</i> (all species) [Culture]		
<input type="checkbox"/>	Cerebral Spinal Fluid (CSF)	<input type="checkbox"/>	<i>E. coli</i> (EHEC, STEC) [Culture]	Viral Typing	
<input type="checkbox"/>	Sputum	<input type="checkbox"/>	<i>Campylobacter spp.</i> (all species) [Culture]	<input type="checkbox"/>	Influenza Typing [PCR]
<input type="checkbox"/>	Urine	<input type="checkbox"/>	<i>Aeromonas spp.</i> (all species) [Culture]	<input type="checkbox"/>	Norovirus Typing [PCR]
<input type="checkbox"/>	Stool	<input type="checkbox"/>	<i>Vibrio spp.</i> (all species) [Culture]		
<input type="checkbox"/>	Swab			Respiratory Viruses	
<input type="checkbox"/>	Bacterial Culture (Slant)			<input type="checkbox"/>	Respiratory Viral Panel [PCR]
<input type="checkbox"/>	Other, please specify:	OCME Only		Virology/Immunology	
		<input type="checkbox"/>	Blood (aerobic)	Arboviral Serology (serum only)	
		<input type="checkbox"/>	Blood (anaerobic)	<input type="checkbox"/>	Zika Virus Serology [IgM]
		<input type="checkbox"/>	CSF		
		<input type="checkbox"/>	Urine	Influenza	
		<input type="checkbox"/>	Other	<input type="checkbox"/>	Influenza A [Viral Culture]
		Tissue Type		<input type="checkbox"/>	Influenza B [Viral Culture]
		<input type="checkbox"/>	Lung		
		<input type="checkbox"/>	Cerebral		
		<input type="checkbox"/>	Gastrointestinal		
		<input type="checkbox"/>	Hepatic		
		<input type="checkbox"/>	Cardiac		
		<input type="checkbox"/>	Reproductive		

Special Instructions:

Indicate if specimen type is other than serum or
urine

PHL USE ONLY