

Commonwealth of Virginia
 Department of General Services
 Division of Consolidated Laboratory Services
 Richmond, Virginia

DCLS Test Request Form

For assistance, please refer to *Instructions for Completing DCLS Test Request Form* (Qualtrax ID # 34961)

PATIENT INFORMATION			SUBMITTER INFORMATION		
Last Name:			Submitting Facility:		
First Name:		M.I.	Address:		
Birth Date: / /		<input type="checkbox"/> Male <input type="checkbox"/> Female	City:		
Address:			State:		Zip code:
City:		State:	Zip code:		Phone:
County:		MRN:	Fax:		
Patient ID:		External ID:		Attending Clinician:	
Race:		Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino		Attending Clinician Phone:	
Phone:		Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No		Public Health Dept Contact:	
				Public Health Contact Phone:	
PATIENT MEDICAL HISTORY					
Disease Suspected or Diagnosis:					
Date of Onset: / /			Deceased Date: / /		
Signs/Symptoms: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Cough <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Headache <input type="checkbox"/> Malaise/Fatigue <input type="checkbox"/> Myalgia <input type="checkbox"/> Pneumonia <input type="checkbox"/> Rash <input type="checkbox"/> Vomiting <input type="checkbox"/> Other:					
Recent Exposure: <input type="checkbox"/> Sexual Contact <input type="checkbox"/> Birds <input type="checkbox"/> Ticks <input type="checkbox"/> Mosquitos <input type="checkbox"/> Other:					
Vaccine Administered:			Vaccine Administration Date: / /		
Antibiotics/Antiviral Used:			Antibiotics/Antiviral Start Date: / /		
Origin country (if not USA):					
Recent Countries visited outside USA:				Dates: / / to / /	
Recent States visited inside USA:				Dates: / / to / /	
OUTBREAK INFORMATION					
Outbreak Related? <input type="checkbox"/> Yes <input type="checkbox"/> No		VDH Designated Outbreak #:			
Role of Patient (ex. Food handler, daycare provider):					
SPECIMEN COLLECTION INFORMATION					
Date Collected: / /			Submitted On (ex. media type, collection container):		
Time Collected: : (military time)		Organism Suspected:			
Reason for Test Request: <input type="checkbox"/> Isolate for ID/Confirmation <input type="checkbox"/> VDH Reportable Disease Compliance <input type="checkbox"/> Surveillance <input type="checkbox"/> Diagnosis <input type="checkbox"/> Contact/Suspected Carrier <input type="checkbox"/> Clearance/Release <input type="checkbox"/> Send Out / Diagnosis <input type="checkbox"/> Other:					
Specimen Source: <input type="checkbox"/> Blood <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Buccal Swab <input type="checkbox"/> Sputum <input type="checkbox"/> Bronchial Wash <input type="checkbox"/> BAL <input type="checkbox"/> Nasopharyngeal Swab <input type="checkbox"/> Oropharyngeal/Throat Swab <input type="checkbox"/> Tissue - type: <input type="checkbox"/> Body Fluid - type: <input type="checkbox"/> Wound - site: <input type="checkbox"/> Other Swab - site: <input type="checkbox"/> Other:					
Follow-up specimen? <input type="checkbox"/> Yes <input type="checkbox"/> No			CIDT Specimen? <input type="checkbox"/> Yes <input type="checkbox"/> No		
PulseNet referral? <input type="checkbox"/> Yes <input type="checkbox"/> No			Date PulseNet specimen received: / /		
Submitter Test Method for ID/Detection:					
Submitter Test Method for AST (if applicable):					
Rapid Test(s) Used (if applicable):			Rapid Test Results:		
ADDITIONAL INFORMATION		*Place Medical Patient Label, if applicable*		*DCLS STATE LAB USE ONLY*	

TEST REQUEST (Place check in box next to desired test)			
Viral Testing			
<input type="checkbox"/> Influenza detection/subtyping <input type="checkbox"/> PCR <input type="checkbox"/> Viral Culture	WNV (West Nile Virus), EEE (Eastern Equine Encephalitis), SLE (Saint Louis Encephalitis, LAC (La Crosse Encephalitis)		
<input type="checkbox"/> Influenza A, un-subtypeable			
<input type="checkbox"/> Novel Influenza	Chikungunya <input type="checkbox"/> PCR <input type="checkbox"/> Serology		
<input type="checkbox"/> Highly Pathogenic Avian Influenza (HPAI)	Dengue <input type="checkbox"/> PCR <input type="checkbox"/> Serology		
<input type="checkbox"/> Measles (Rubeola) * <input type="checkbox"/> PCR <input type="checkbox"/> Viral Culture <input type="checkbox"/> Serology	Zika <input type="checkbox"/> PCR <input type="checkbox"/> Serology		
<input type="checkbox"/> Mumps * <input type="checkbox"/> PCR <input type="checkbox"/> Viral Culture <input type="checkbox"/> Serology	Other Arbovirus:		
<input type="checkbox"/> Varicella Zoster Virus (VZV) * <input type="checkbox"/> PCR <input type="checkbox"/> Viral Culture	Ebola Virus *		
<input type="checkbox"/> Smallpox (Variola virus) *†	Coronavirus infection * Suspected Virus:		
<input type="checkbox"/> Smallpox Vaccine Adverse Event (Vaccinia virus) *	Viral Culture for ID Suspected ID:		
Biothreat Rule Out / Confirmatory Testing		Bacteriology ID / Detection	
<input type="checkbox"/> Anthrax (<i>Bacillus anthracis</i>)†^	PulseNet Sample Submitter Key ID #:		
<input type="checkbox"/> Botulism (<i>Clostridium botulinum</i>) *†	Bacterial isolate for ID Suspected ID:		
<input type="checkbox"/> Brucellosis (<i>Brucella</i> species)† <input type="checkbox"/> PCR <input type="checkbox"/> Serology	Bacterial Meningitis (PCR)		
<input type="checkbox"/> <i>Burkholderia mallei</i> / <i>pseudomallei</i> †	Carbapenem Resistant Organism**		
<input type="checkbox"/> Plague (<i>Yersinia pestis</i>)†	Suspected ID:		
<input type="checkbox"/> Q fever (<i>Coxiella burnetii</i>)†	Diphtheria (<i>Corynebacterium diphtheriae</i>)		
<input type="checkbox"/> Tularemia (<i>Francisella tularensis</i>)†	<i>Haemophilus influenzae</i> infection, invasive		
Enteric Culture / ID / Detection††		Mycology	
<input type="checkbox"/> <i>Campylobacteriosis</i> (<i>Campylobacter</i> species)	Listeriosis (<i>Listeria monocytogenes</i>)		
<input type="checkbox"/> Enteric Screen Culture (VDH request only)	Meningococcal disease (<i>Neisseria meningitidis</i>)		
<input type="checkbox"/> Enterotoxigenic <i>B. cereus</i> (VDH request only)	Pertussis / <i>Bordetella</i> species <input type="checkbox"/> Culture <input type="checkbox"/> PCR		
<input type="checkbox"/> Enterotoxigenic <i>C. perfringens</i> (VDH request only)	Streptococcal disease, Group A (<i>S. pyogenes</i>), invasive		
<input type="checkbox"/> Enterotoxigenic <i>S. aureus</i> (VDH request only)	Vancomycin-intermediate/resistant <i>S. aureus</i> (VISA/VRSA)**		
<input type="checkbox"/> Norovirus (VDH request only)	<i>Vibrio</i> species		
<input type="checkbox"/> Salmonellosis (<i>Salmonella</i> species)	Other:		
<input type="checkbox"/> Shiga toxin-producing <i>Escherichia coli</i> infection (STEC)	Actinomycete for ID Suspected ID:		
<input type="checkbox"/> Shigellosis (<i>Shigella</i> species)	<i>Candida</i> species <input type="checkbox"/> <i>C. auris</i> <input type="checkbox"/> <i>C. haemulonii</i>		
<input type="checkbox"/> Vibriosis (<i>Vibrio</i> species) / Cholera (<i>Vibrio cholerae</i> O1/O139)	Mold for ID Suspected ID:		
<input type="checkbox"/> Yersiniosis (<i>Yersinia</i> species) (other than <i>pestis</i>)	Yeast isolate for ID Suspected ID:		
Send Out Testing^^		Mycobacteriology / AFB	
<input type="checkbox"/> Test Request:	<i>Mycobacterium tuberculosis</i> complex (compliance)		
<input type="checkbox"/>	<i>M. tuberculosis</i> complex Genotyping (VDH request only)		
<input type="checkbox"/>	Nontuberculous Mycobacteria ID (VDH request only)		
Miscellaneous			
Congenital Cytomegalovirus – Newborn Screening		Adult Sickle Cell	
Date of Failed Hearing Test: / /		Previous transfusion?	
External ID #:		Transfusion Date: / /	
Mother's Name:		Testing Reason: <input type="checkbox"/> Routine <input type="checkbox"/> Premarital <input type="checkbox"/> Prenatal	
Mother's Date of Birth: / /		<input type="checkbox"/> Family Planning <input type="checkbox"/> Family Study <input type="checkbox"/> Amnio Patient	
Pediatrician Name:		<input type="checkbox"/> Confirm known disease or trait <input type="checkbox"/> Other:	
Pediatrician Phone:		ABO Testing – Blood Group and Rh Type	
Pediatrician Address:		Was Rhogam given? <input type="checkbox"/> Yes <input type="checkbox"/> No	
City: State: Zip code:		If yes, Testing date: / /	
Malaria (EDTA Blood specimen only)		Was a previous antibody identified? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Rubella Immunity Screening		If so, what was the antibody?	
Other:			

* VDH approval is required prior to submission. † Possible Select Agent – Notification and consultation with DCLS is required prior to submission.
 ** Submission must include a copy of laboratory susceptibility testing results. †† Submission should include a copy of laboratory CIDT report for specimens, if applicable.
 ^ Routine rule out testing of *Bacillus* species does **NOT** require prior notification or consultation with DCLS.
 ^^ Specimens for Send Out Testing may require additional documentation. Please consult with DCLS prior to submission.