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: / /	☐ Male ☐ Female	City:	
Address:		State:	Zip code:
City:	State: Zip code:	Phone:	Fax:
County:	MRN:	Attending Clinician:	
Patient ID:	External ID:	Attending Clinician Phone:	
Race:	Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino	Public Health Dept Contact:	
Phone:	Pregnant: ☐ Yes ☐ No	Public Health Contact Phone:	

PATIENT MEDICAL HISTORY

Disease Suspected or Diagnosis:

Date of Onset: / / | Deceased Date: / /

Signs/Symptoms: ☐ *Asymptomatic* ☐ *Abdominal Pain* ☐ *Cough* ☐ *Diarrhea* ☐ *Fever* ☐ *Headache* ☐ *Malaise/Fatigue* ☐ *Myalgia* ☐ *Pneumonia* ☐ *Rash* ☐ *Vomiting* ☐ *Other:*

Recent Exposure: ☐ *Sexual Contact* ☐ *Birds* ☐ *Ticks* ☐ *Mosquitos* ☐ *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? ☐ *Yes* ☐ *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: ☐ *Isolate for ID/Confirmation* ☐ *VDH Reportable Disease Compliance* ☐ *Surveillance* ☐ *Diagnosis* ☐ *Contact/Suspected Carrier* ☐ *Clearance/Release* ☐ *Send Out / Diagnosis* ☐ *Other:*

Specimen Source: ☐ *Blood* ☐ *Serum* ☐ *CSF* ☐ *Urine* ☐ *Stool* ☐ *Buccal Swab* ☐ *Sputum* ☐ *Bronchial Wash* ☐ *BAL* ☐ *Nasopharyngeal Swab* ☐ *Oropharyngeal/Throat Swab* ☐ *Tissue - type:* ☐ *Body Fluid - type:* ☐ *Wound - site:* ☐ *Other Swab – site:* ☐ *Other:*

Follow-up specimen? ☐ *Yes* ☐ *No* | CIDT Specimen? ☐ *Yes* ☐ *No*

PulseNet referral? ☐ *Yes* ☐ *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*

Patient Name / Identifier ________________________________ Date of Birth ____ / ____ / _______

TEST REQUEST (Place check in box next to desired test)

Viral Testing

☐	Test	☐	Test
☐	Influenza detection/subtyping ☐ PCR ☐ Viral Culture	☐	WNV (West Nile Virus), EEE (Eastern Equine Encephalitis), SLE (Saint Louis Encephalitis, LAC (La Crosse Encephalitis)
☐	Influenza A, un-subtypeable		
☐	Novel Influenza	☐	Chikungunya ☐ PCR ☐ Serology
☐	Highly Pathogenic Avian Influenza (HPAI)	☐	Dengue ☐ PCR ☐ Serology
☐	Measles (Rubeola) * ☐ PCR ☐ Viral Culture ☐ Serology	☐	Zika ☐ PCR ☐ Serology
☐	Mumps * ☐ PCR ☐ Viral Culture ☐ Serology	☐	Other Arbovirus:
☐	Varicella Zoster Virus (VZV) * ☐ PCR ☐ Viral Culture	☐	Ebola Virus *
☐	Smallpox (Variola virus) *†	☐	Coronavirus infection * | Suspected Virus:
☐	Smallpox Vaccine Adverse Event (Vaccinia virus) *	☐	Viral Culture for ID | Suspected ID:

☐	Biothreat Rule Out / Confirmatory Testing	☐	Bacteriology ID / Detection
☐	Anthrax *(Bacillus anthracis)*†^	☐	PulseNet Sample | Submitter Key ID #:
☐	Botulism (*Clostridium botulinum*) *†	☐	Bacterial isolate for ID | Suspected ID:
☐	Brucellosis *(Brucella* species)† ☐ PCR ☐ Serology	☐	Bacterial Meningitis (PCR)
☐	*Burkholderia mallei* / *pseudomallei*†	☐	Carbapenem Resistant Organism** Suspected ID:
☐	Plague *(Yersinia pestis)*†		
☐	Q fever *(Coxiella burnetii)*†	☐	Diphtheria *(Corynebacterium diphtheriae)*
☐	Tularemia *(Francisella tularensis)*†	☐	*Haemophilus influenzae* infection, invasive
	Enteric Culture / ID / Detection††	☐	Listeriosis *(Listeria monocytogenes)*
☐	*Campylobacteriosis (Campylobacter* species)	☐	Meningococcal disease *(Neisseria meningitidis)*
☐	Enteric Screen Culture (VDH request only)	☐	Pertussis / *Bordetella* species ☐ Culture ☐ PCR
☐	Enterotoxigenic *B. cereus* (VDH request only)	☐	Streptococcal disease, Group A (*S. pyogenes*), invasive
☐	Enterotoxigenic *C. perfringens* (VDH request only)	☐	Vancomycin-intermediate/resistant *S. aureus* (VISA/VRSA)**
☐	Enterotoxigenic *S. aureus* (VDH request only)	☐	*Vibrio* species
☐	Norovirus (VDH request only)	☐	Other:
☐	Salmonellosis *(Salmonella* species)		**Mycology**
☐	Shiga toxin-producing *Escherichia coli* infection (STEC)	☐	Actinomycete for ID | Suspected ID:
☐	Shigellosis *(Shigella* species)	☐	*Candida* species ☐ *C. auris* ☐ *C. haemulonii*
☐	Vibriosis *(Vibrio* species) / Cholera *(Vibrio cholerae O1/O139)*	☐	Mold for ID | Suspected ID:
☐	Yersiniosis *(Yersinia* species) (other than *pestis*)	☐	Yeast isolate for ID | Suspected ID:

☐	Send Out Testing^^	☐	Mycobacteriology / AFB
☐	Test Request:	☐	*Mycobacterium tuberculosis* complex (compliance)
☐		☐	*M. tuberculosis* complex Genotyping (VDH request only)
☐		☐	Nontuberculous Mycobacteria ID (VDH request only)

Miscellaneous

☐	Test	☐	Test
☐	**Congenital Cytomegalovirus – Newborn Screening**	☐	**Adult Sickle Cell**
	Date of Failed Hearing Test: / /		Previous transfusion?
	External ID #:		Transfusion Date: / /
	Mother's Name:		Testing Reason: ☐ Routine ☐ Premarital ☐ Prenatal
	Mother's Date of Birth: / /		☐ Family Planning ☐ Family Study ☐ Amnio Patient
	Pediatrician Name:		☐ Confirm known disease or trait ☐ Other:
	Pediatrician Phone:	☐	**ABO Testing – Blood Group and Rh Type**
	Pediatrician Address:		Was Rhogam given? ☐ Yes ☐ No
	City: | State: | Zip code:		If yes, Testing date: / /
☐	**Malaria (EDTA Blood specimen only)**		Was a previous antibody identified? ☐ Yes ☐ No
☐	**Rubella Immunity Screening**		If so, what was the antibody?
☐	**Other:**		

* VDH approval is required prior to submission.

** Submission must include a copy of laboratory susceptibility testing results.

† Possible Select Agent – Notification and consultation with DCLS is required prior to submission.

†† 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.

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