Approval from the health department MUST be obtained before sending specimens to DCLS.

INSTRUCTIONS

- Highlighted fields must be completed. Enter other information as known.
- Name and Birth Date MUST match specimen label.
- You may use 1 form for multiple specimens from the same patient.
  *If more than NP specimen, select specimen types and if serology is ordered.

For questions, contact Clarissa Bonnefond with the Lord Fairfax Health District: 804-517-5773

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**: Winchester Medical Center	
First Name:		M.I.	Address: 1840 Amherst St.	
Birth Date: / /	☐ Male ☐ Female		City: Winchester	
Address:			State: VA	Zip code: 22601
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: Clarissa Bonnefond	
Phone:	Pregnant: ☐ Yes ☐ No		Public Health Contact Phone: 804-517-5773	

PATIENT MEDICAL HISTORY

Disease Suspected or Diagnosis: Measles

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: measles

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

	Influenza detection/subtyping ☐ PCR ☐ Viral Culture		WNV (West Nile Virus), EEE (Eastern Equine Encephalitis),
	Influenza A, un-subtypeable		SLE (Saint Louis Encephalitis, LAC (La Crosse Encephalitis)
	Novel Influenza		Chikungunya ☐ PCR ☐ Serology
	Highly Pathogenic Avian Influenza (HPAI)		Dengue ☐ PCR ☐ Serology
* x	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

	Anthrax *(Bacillus anthracis)*†^
	Botulism (*Clostridium botulinum*) *†
	Brucellosis *(Brucella* species)† ☐ PCR ☐ Serology
	Burkholderia mallei / pseudomallei†
	Plague *(Yersinia pestis)*†
	Q fever *(Coxiella burnetii)*†
	Tularemia *(Francisella tularensis)*†

Enteric Culture / ID / Detection††

	Campylobacteriosis (Campylobacter species)
	Enteric Screen Culture (VDH request only)
	Enterotoxigenic *B. cereus* (VDH request only)
	Enterotoxigenic *C. perfringens* (VDH request only)
	Enterotoxigenic *S. aureus* (VDH request only)
	Norovirus (VDH request only)
	Salmonellosis *(Salmonella* species)
	Shiga toxin-producing *Escherichia coli* infection (STEC)
	Shigellosis *(Shigella* species)
	Vibriosis *(Vibrio* species) / Cholera *(Vibrio cholerae O1/O139)*
	Yersiniosis *(Yersinia* species) (other than *pestis*)

Send Out Testing^^

	Test Request:

Bacteriology ID / Detection

	PulseNet Sample Submitter Key ID #:
	Bacterial isolate for ID Suspected ID:
	Bacterial Meningitis (PCR)
	Carbapenem Resistant Organism**
	Suspected ID:
	Diphtheria *(Corynebacterium diphtheriae)*
	Haemophilus influenzae infection, invasive
	Listeriosis *(Listeria monocytogenes)*
	Meningococcal disease *(Neisseria meningitidis)*
	Pertussis / *Bordetella* species ☐ Culture ☐ PCR
	Streptococcal disease, Group A (*S. pyogenes*), invasive
	Vancomycin-intermediate/resistant *S. aureus* (VISA/VRSA)**
	Vibrio species
	Other:

Mycology

	Actinomycete for ID Suspected ID:
	Candida species ☐ *C. auris* ☐ *C. haemulonii*
	Mold for ID Suspected ID:
	Yeast isolate for ID Suspected ID:

Mycobacteriology / AFB

	Mycobacterium tuberculosis complex (compliance)
	M. tuberculosis complex Genotyping (VDH request only)
	Nontuberculous Mycobacteria ID (VDH request only)

Miscellaneous

	Congenital Cytomegalovirus – Newborn Screening
	Date of Failed Hearing Test: / /
	External ID #:
	Mother's Name:
	Mother's Date of Birth: / /
	Pediatrician Name:
	Pediatrician Phone:
	Pediatrician Address:
	City: State: Zip code:
	Malaria (EDTA Blood specimen only)
	Rubella Immunity Screening
	Other:

	Adult Sickle Cell
	Previous transfusion?
	Transfusion Date: / /
	Testing Reason: ☐ Routine ☐ Premarital ☐ Prenatal
	☐ Family Planning ☐ Family Study ☐ Amnio Patient
	☐ Confirm known disease or trait ☐ Other:
	ABO Testing – Blood Group and Rh Type
	Was Rhogam given? ☐ Yes ☐ No
	If yes, Testing date: / /
	Was a previous antibody identified? ☐ Yes ☐ No
	If so, what was the antibody?

* 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.