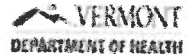


# Vermont Department of Health Laboratory - Clinical Test Request Form



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: _____ 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 _____ Fax Number (for a faxed result) _____	MRN# or ID# _____ Specimen ID# _____
Referring Physician Last Name/first Name _____	Date of Birth (MM/DD/YYYY) _____
NPI # _____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Comments: _____	Race <input type="checkbox"/> African American or Black <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Multiracial <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other
	Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Other

<input type="checkbox"/> Check if no insurance			Billing Information – Attach Copy of Insurance Card		
Responsible Party Name _____		Medicaid Number _____	Medicare Number _____		
Insurance Company Name _____		ID Number _____	Group Number _____		
Subscriber Name _____		Relationship _____			

Specimen Source		
<input type="checkbox"/> Aspirate site: _____	<input type="checkbox"/> Fluid-site: _____	<input type="checkbox"/> Sputum
<input type="checkbox"/> Biopsy tissue site: _____	<input type="checkbox"/> Isolate-source: _____	<input type="checkbox"/> Stool
<input type="checkbox"/> Blood, Venous	<input type="checkbox"/> Lymph Node	<input type="checkbox"/> Swab
<input type="checkbox"/> Bone	<input type="checkbox"/> Nasal Swab	<input type="checkbox"/> Urine
<input type="checkbox"/> Bronchial Wash	<input type="checkbox"/> Nasopharyngeal Swab	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Bronchoalveolar Brush	<input type="checkbox"/> Nasal Wash	
<input type="checkbox"/> Bronchoalveolar Lavage	<input type="checkbox"/> Oral Mucosal Transudate (Oral Fluid)	
<input type="checkbox"/> Cerebral Spinal Fluid	<input type="checkbox"/> Serum: <input type="checkbox"/> Acute <input type="checkbox"/> Convalescent	

Specimen Site	Reason for Test
<input type="checkbox"/> Cervix	<input type="checkbox"/> Confirmation/Reference
<input type="checkbox"/> Endocervix	<input type="checkbox"/> Contact/Exposure
<input type="checkbox"/> Lung	<input type="checkbox"/> Diagnostic
<input type="checkbox"/> Nasal Mucosa	<input type="checkbox"/> Hospitalized
<input type="checkbox"/> Nasopharynx	<input type="checkbox"/> Immigrant/Refugee
<input type="checkbox"/> Oral	<input type="checkbox"/> VDHL Request
<input type="checkbox"/> Perianal	<input type="checkbox"/> Immune Status
<input type="checkbox"/> Rectal	<input type="checkbox"/> Outbreak: _____
<input type="checkbox"/> Throat	<input type="checkbox"/> Facility Name: _____
<input type="checkbox"/> Urethra	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Vaginal	<input type="checkbox"/> Screen
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Symptomatic

For Laboratory Use Only	
<input type="checkbox"/> Transport medium expired	<input type="checkbox"/> Duplicate of # _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Overfilled <input type="checkbox"/> QNS/Leaked in Transit <input type="checkbox"/> Too Old to Test
VDH EPI notified of receipt of isolate: _____	Shipping Temperature upon arrival: <input type="checkbox"/> Cold <input type="checkbox"/> Room Temp.
VDH EPI notified of preliminary results: _____	Result: _____
VDH EPI notified of final results: _____	Provider notified of preliminary results: _____
	Provider notified of final results: _____

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PLEASE COMPLETE BACK SIDE

