Vermont Department of Health Laboratory - Clinical Test Request Form

VERMONT DEPARTMENT OF HEALTH

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

Date of Collection: _____ Date of Onset: _____

Time of Collection: _____ ICD Code: _____

For Laboratory Use Only

LIMS # Date Received:

Clinical Lab/Practice Information

Clinical Laboratory/ Practice Name		
Address		
City/Town	**State**	**Zip code**
Telephone Number	**Fax Number (for a faxed result)**	
Referring Physician Last Name/first Name		
NPI #		

Comments:

Patient Information

Last Name	**First Name**	
Address		
City/Town	**State**	**Zip code**
MRN# or ID#	**Specimen ID#**	
Date of Birth (MM/DD/YYYY)		

Gender
☐ Male ☐ Female ☐ Other

Race
☐ African American or Black ☐ American Indian or Alaska Native ☐ Asian
☐ Multiracial ☐ Pacific Islander ☐ White ☐ Unknown ☐ Other

Ethnicity
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Other

Billing Information – Attach Copy of Insurance Card

☐ Check if no insurance

Responsible Party Name	**Medicaid Number**	**Medicare Number**
Insurance Company Name	**ID Number**	**Group Number**
Subscriber Name	**Relationship**	

Specimen Source

☐ Aspirate site: _____	☐ Fluid-site: _____	☐ Sputum
☐ Biopsy tissue site: _____	☐ Isolate-source: _____	☐ Stool
☐ Blood, Venous	☐ Lymph Node	☐ Swab
☐ Bone	☐ Nasal Swab	☐ Urine
☐ Bronchial Wash	☐ Nasopharyngeal Swab	☐ Other:
☐ Bronchoalveolar Brush	☐ Nasal Wash	
☐ Bronchoalveolar Lavage	☐ Oral Mucosal Transudate (Oral Fluid)	
☐ Cerebrospinal Fluid	☐ Serum: ☐ Acute ☐ Convalescent	

Specimen Site

☐ Cervix	☐ Perianal
☐ Endocervix	☐ Rectal
☐ Lung	☐ Throat
☐ Nasal Mucosa	☐ Urethra
☐ Nasopharynx	☐ Vaginal
☐ Oral	☐ Other:

Reason for Test

☐ Confirmation/Reference	☐ Immune Status
☐ Contact/Exposure	☐ Outbreak:
☐ Diagnostic	Facility Name: _____
☐ Hospitalized	☐ Pregnancy
☐ Immigrant/Refugee	☐ Screen
☐ VDHL Request	☐ Symptomatic

For Laboratory Use Only

☐ Transport medium expired ☐ Duplicate of # _____ ☐ Overfilled ☐ QNS/Leaked in Transit ☐ Too Old to Test

☐ Other:_____ Shipping Temperature upon arrival: ☐ Cold ☐ Frozen ☐ Room Temp.

Result: _____

Provider notified of preliminary results: _____ Provider notified of final results:_____

Specimen storage condition prior to shipment: ☐ Refrigerated ☐ Frozen ☐ Room

Culture Independent Diagnostic Test (CIDT) Positive Stool Samples Sent Per VDH Requirement

Send original stool sample for the following:

☐ Campylobacter
☐ Shiga toxin producing E. coli (STEC)
☐ Salmonella
☐ Shigella
☐ Vibrio
☐ Other:

Bacteriology Diagnostic Test

☐ Enteric screen (Salmonella, Shigella, E. coli (STEC), Campylobacter, Yersinia, Vibrio)
☐ Gonorrhea/Chlamydia PCR
☐ Pertussis culture
☐ Pertussis culture & PCR (B. pertussis, B parapertussis, B. holmseii)
☐ Isolate for identification:
☐ Other:

Carbapenem Resistant Organisms

☐ Carbapenem-resistant Acinetobacter baumannii (CRAB)*
☐ Carbapenem-resistant Enterobacterales (CRE)*
☐ Carbapenem-resistant Pseudomonas aeruginosa (CRPA)*
* Please include a copy of the antimicrobial susceptibility test results

Isolates Sent Per VDH Requirement

☐ Haemophilus influenzae typing (isolated from a sterile site)
☐ Legionella
☐ Listeria monocytogenes
☐ Neisseria gonorrhea
☐ Neisseria meningitidis (isolated from a sterile site)
☐ Invasive Group A Streptococcus
☐ Other:

Biothreat Agents (Call VDHL Prior To Sending)

☐ Bacillus anthracis ☐ Burkholderia
☐ Brucella ☐ Francisella tularensis
☐ Smallpox ☐ Yersinia pestis
☐ Other:

Mycobacteriology/Mycology

☐ Candida auris
☐ Mycobacterial Culture/Smear
☐ Mycobacterial/Fungal Culture
☐ NAAT for Direct Detection of MTB in Specimen
☐ Yeast ID – Invasive, drug resistant, or unidentified isolate
☐ Isolate for identification:_____
☐ Other:

Parasitology

☐ Cryptosporidium EIA ☐ Giardia EIA
☐ Ova and parasites (O & P) ☐ Cyclospora/Cystoisospora
☐ Pinworm Identification ☐ Worm Identification
☐ Other:

Serology

☐ Brucella Total Antibody
☐ Hepatitis B Panel (Surface Antigen, Surface Antibody, Core Total Antibody)
☐ Hepatitis B Surface Antigen
☐ Hepatitis B Core Total Antibody
☐ Hepatitis B Surface Antibody (for vaccine response)
☐ Hepatitis C Antibody
☐ HIV-1/HIV-2 Antibody and p24 Antigen EIA (serum)
☐ HIV-1 Antibody EIA (oral fluid)
☐ Legionella pneumophila Antigen (urine)
☐ Measles IgG EIA
☐ Mumps IgG EIA
☐ Rubella IgG EIA
☐ Varicella zoster IgG EIA
☐ Syphilis – RPR Screen with reflex to RPR titer and FTA
☐ QuantiFERON-TB Gold Plus EIA (IGRA)
Tubes incubated at 37°C: ☐ YES ☐ NO
Incubation Date/Time Start: _____
End: _____
☐ Other:

Serology Tests Requiring Authorization From Vermont Epidemiology

☐ Measles IgM EIA*
☐ Rubella IgM EIA*
*obtain approval for testing by calling the Epidemiology unit at 802-863-7240

Molecular Virology

☐ Ebola PCR
☐ Influenza A & B PCR
Foreign travel within 10 days of illness onset ☐ YES ☐ NO
Location of travel:_____
☐ MPOX PCR
☐ Norovirus PCR
☐ RSV PCR (includes SARS-CoV-2 and Influenza A & B)
☐ SARS-CoV-2 PCR
☐ Other:

Molecular Virology Tests Requiring Authorization From Vermont Epidemiology

☐ Measles PCR**
☐ Mumps PCR**
**obtain approval for testing by calling the Epidemiology unit at 802-863-7240

Positive Virology Specimens Sent Per VDH Request

☐ Arbovirus (list name): _____
☐ Influenza A
☐ Influenza B
☐ SARS-CoV-2
☐ Other: