♦Name and Address of Authorized Submitter

LAB PROFILE Number:

CLINICAL TEST REQUISITION

STATE OF CONNECTICUT

Dr. Katherine A. Kelley State Public Health Laboratory
395 West Street, Rocky Hill, CT 06067
CLIA ID 07D0644555 / CT License CL-0197
Phone 860-920-6500
CLIENT SERVICES 860-920-6635

ACCESSION LABEL

FOR LABORATORY USE ONLY

♦ DENOTES REQUIRED INFORMATION

Section 1: Patient Information (*Please Print Clearly*)

♦ Name (Last, First, M.I.) or Identifier:

♦ Street Address: **♦ City, State, Zip:**

♦ Date of Birth: Gender: ☐ Female ☐ Male ☐ Unknown Home Phone:

Race (check all that apply): **(♦ Race/Ethnicity Information is Required for Blood Lead)**
☐ White ☐ Black/African Amer. ☐ Asian ☐ Amer. Indian/Alaska Nat. ☐ Nat. Hawaiian/Other Pacific Islander ☐ Other ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

International travel within the past 21 days? ☐ Yes ☐ No ☐ Unknown Location(s) ______________ ______________ ______________

Ordering Healthcare Provider: Phone:

Section 2: Specimen Information

Submitter Sample ID: **♦ Date Collected:** Time Collected: ☐ AM ☐ PM

♦ Specimen Source/Type:

☐ Blood ☐ Bronchial Wash ☐ Cervix ☐ CSF ☐ Lymph Node ☐ Nasopharynx ☐ Oral Fluid
☐ Rectal ☐ Serum ☐ Sputum ☐ Stool ☐ Throat ☐ Urethra ☐ Urine

☐ Body Fluid, specify ____________________________________ ☐ Tissue, specify ____
☐ Other, specify ____

♦ Section 3: Select Testing Requested

Bacteriology

- ☐ AFB Clinical Specimen (Mycobacteria Smear & Culture)
- ☐ AFB Referred Culture (Mycobacteria for Identification)
- ☐ Bioterrorism Agent Identification
  specify agent:________________________________
- ☐ Bordetella pertussis (DFA, Culture, or Isolate)
- ☐ Chlamydia & Gonorrhea DNA Probe
- ☐ EIP Isolates for Identification **(Check one)**
  ☐ Group A *Streptococcus* ☐ *H. influenzae* ☐ *L. monocytogenes*
  ☐ *N. meningitidis* ☐ *S. pneumoniae* ☐ Other: __________________
- ☐ Enteric Isolate for Identification
  ☐ *Campylobacter* ☐ *E. coli O157* ☐ *Salmonella* ☐ *Shigella*
  ☐ *Shiga-toxin producing E. coli* ☐ *Vibrio* ☐ Other: _______________
- ☐ Enteric (Stool) Culture
- ☐ *Neisseria gonorrhoeae* Culture
- ☐ Shiga-toxin (+) Broth Culture

Bacterial Serology

- ☐ QuantiFeron-TB Test **(Specify ♦ Date & Time Collected Above)**
- ☐ Syphilis Screen (VDRL)
- ☐ Syphilis Confirmation (VDRL & TP-PA)
- ☐ Syphilis CSF (VDRL Only)

Blood Lead (Uninsured Patients ONLY) ♦ Race/Ethnicity Required

- ☐ Child Lead Screen (Capillary Blood)
- ☐ Lead Confirmation (Venous Blood)

Parasitology

- ☐ Blood Parasite - Smear
- ☐ Parasite (Fecal) – Gross Identification

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Virology

- ☐ Arbovirus Panel (Encephalitis Viruses)
  California Group, Eastern Equine, St. Louis, Western Equine
- ☐ Cytomegalovirus IgG Antibody
- ☐ Cytomegalovirus IgM Antibody
- ☐ Hepatitis B Surface Antibody
- ☐ Hepatitis B Surface Antigen
- ☐ Hepatitis C Testing
- ☐ Herpes Simplex IgG Antibody
- ☐ Herpes Simplex PCR
- ☐ HIV-1/HIV-2 Testing
- ☐ HIV STARHS Referral
- ☐ Influenza PCR
- ☐ Measles PCR
- ☐ MERS CoV **(Epidemiology Approval Required)**
- ☐ Mumps PCR
- ☐ Norovirus PCR **(Epidemiology Approval Required)**
- ☐ Respiratory Virus Antigen Panel: *Adenovirus, Influenza A&B, Metapneumovirus, Parainfluenza 1-3, Rhinovirus/Enterovirus, RSV A&B*
- ☐ Varicella Zoster IgG Antibody
- ☐ West Nile Virus IgM Antibody
- ☐ Virus Identification (Culture)

Test, Agent or Disease, Not Listed (Specify)

Comments (270 spaces)