

# Specimen Submission Form

STATE LABORATORY INSTITUTE

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Do not use this space

PLEASE PRINT

DO NOT ABBREVIATE

## 1. SEND RESULTS TO :

Facility/Laboratory \_\_\_\_\_

Address \_\_\_\_\_

Phone number : (     ) \_\_\_\_\_

## 2. PATIENT INFORMATION

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone (     ) \_\_\_\_\_

Patient ID \_\_\_\_\_

## 3. ORDERING PHYSICIAN/CONTACT - Name

Phone Number: (     ) \_\_\_\_\_

## 5. TEST REQUESTED:

Reason:  Symptomatic     Test of Cure     Surveillance  
 Confirmation                       Contact

Presumptive ID: \_\_\_\_\_

For:     Identification     Isolation     Typing  
(-----Complete Section 7-----)

Serology (Complete Section 6)

Other (specify) \_\_\_\_\_

4. Sex     M     F     Other

Date of Birth

\_\_\_\_/\_\_\_\_/\_\_\_\_

Ethnicity

Hispanic or Latino     Not Hispanic or Latino

Race

(check one)

- American Indian or Alaska Native  
 Asian  
 Black or African American  
 Native Hawaiian or Other Pacific Islander  
 White  
 Other

## 6. SEROLOGY:

Serum     Spinal Fluid

Acute     Convalescent     Late Convalescent

Date Collected \_\_\_\_/\_\_\_\_/\_\_\_\_

7. CULTURE: Specimen submitted is: (Please check one and complete date collected or date of subculture)

Original Material. Date Collected: \_\_\_\_/\_\_\_\_/\_\_\_\_     Subculture. Date Subculture made: \_\_\_\_/\_\_\_\_/\_\_\_\_

Has specimen been treated?  Yes  No    Specify Method \_\_\_\_\_

## Source of Specimen:

- |                                      |                                       |  |   |
|--------------------------------------|---------------------------------------|--|---|
| <input type="checkbox"/> Anal Canal  | <input type="checkbox"/> Pharynx      | <input type="checkbox"/> Throat            | <input type="checkbox"/> Wound (site)     |
| <input type="checkbox"/> Blood       | <input type="checkbox"/> Plasma       | <input type="checkbox"/> Urethra           |   |
| <input type="checkbox"/> Bone marrow | <input type="checkbox"/> Serum        | <input type="checkbox"/> Urine             | <input type="checkbox"/> Exudate (site)   |
| <input type="checkbox"/> Cervix      | <input type="checkbox"/> Spinal Fluid |  |   |
| <input type="checkbox"/> Gastric     | <input type="checkbox"/> Sputum       | <input type="checkbox"/> Body Fluid (site) | <input type="checkbox"/> Tissue (specify) |
| <input type="checkbox"/> Nasopharynx | <input type="checkbox"/> Stool        |  |   |
|                                      |                                       | <input type="checkbox"/> Bronchus (site)   | <input type="checkbox"/> Other (specify)  |

## 8. FOR VIRUS SEROLOGY, VIRUS ISOLATION and TESTS LISTED AS CDC SEROLOGY or CDC CULTURE IN THE SLI MANUAL OF TESTS and SERVICES.

Symptoms, Date of Onset and Duration \_\_\_\_\_

Travel History (and dates of travel) \_\_\_\_\_

Animal/Arthropod Contact (specify) \_\_\_\_\_

Previous Laboratory Results \_\_\_\_\_

Relevant Immunizations (give dates) \_\_\_\_\_

Additional Information: \_\_\_\_\_

**INSTRUCTIONS:** If a section does not apply to a given situation, write N/A (not applicable). For more information on SLI testing, see the SLI Manual of Tests and Services at <http://www.mass.gov/dph/bls/>