GENERAL MICROBIOLOGY REQUEST

Oregon State Public Health Laboratory (OSPHL)
7202 NE Evergreen Pkwy. Suite 100; Hillsboro, OR 97124
Information: 503-693-4100

Oregon Health Authority

PATIENT INFORMATION

*Patient last name, first, middle initial:

*Date of birth (mm/dd/yyyy):

*Sex/gender: ◯ Female ◯ F to M ◯ Male ◯ M to F

Patient ID/Chart number:

Race:
☐ American Indian or Alaska Native ☐ Asian
☐ Black or African American ☐ White
☐ Native Hawaiian or Other Pacific Islander
☐ Multi-race ☐ Other ☐ Unknown ☐ Declined

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown
☐ Declined

Patient street address:

City: State: ZIP:

*County of Residence: Outbreak number:

*Submitting facility:

*Ordering clinician:

Contact number:

Copy results to: ☐ County of Residence ☐ State Public Health
☐ Other Public Health: _____

PATIENT INSURANCE INFORMATION

*Insurance/Health plan name: ☐ None | Policy no/Member ID: | Group ID: | Diagnosis/ICD-10 code for test:

SPECIMEN / ISOLATE INFORMATION

*Date of collection: | Time of collection (##:##): ◯ AM ◯ PM | Illness onset date: | Specimen submitted in (*list media/preservative*):

*Original specimen source: ☐ Blood ☐ Nasopharyngeal swab ☐ Sputum ☐ Stool ☐ Urine ☐ Wound ☐ Other: _____

Submitting: ◯ Original material ◯ Isolate | Was an original test performed on a CIDT platform? ◯ No ◯ Yes ☐ Reports attached. Platform: _____

*TESTS REQUESTED — Please choose one:

ENTERICS — CULTURE OR ISOLATE IDENTIFICATION

	Original material:	Isolate:
Aeromonas spp.		☐ ID (AERID)
Campylobacter spp.	☐ Culture (CAMC)	☐ ID (CAMID)
E. coli O157		☐ ID (O157ID)
Enteric Pathogen Screen	☐ Culture (ENTC)	
Plesiomonas shigelloides	☐ Culture (PLEC)	☐ ID (PLEID)
Salmonella spp.	☐ Culture (SALC)	☐ ID (SALID)
Shiga toxin producing *E. coli*	☐ Culture (STECCUL)	
Shigella spp.	☐ Culture (SHIC)	☐ ID (SHIGID)
Vibrio spp.	☐ Culture (VIBC)	☐ ID (VIBID)
Yersinia spp. (non-*Y. pestis*)	☐ Culture (YERC)	☐ ID (YERID)

MYCOBACTERIA

☐ AFB: Smear/culture; sputum or primary specimen

☐ AFBPCR: AFB Culture Identification PCR; isolate
Date culture positive: _____

☐ AFBSUSC: *M. tuberculosis* complex susceptibility testing; isolate
Date culture positive: _____

☐ QFT PLUS: QuantiFERON® Plus
Must be received within **16 hours** of collection, Mon.–Fri. before 5 p.m.
Time of collection (*mandatory, ##:##*): ◯ AM ◯ PM

SEROTYPING — Notify the OSPHL if expedited handling is indicated.

☐ HAES: *Haemophilus influenzae* serotype

☐ NEIS: *Neisseria meningitidis* serogroup

MISCELLANEOUS TESTING

☐ *Bordetella* spp. Culture and PCR *B. pertussis, B. parapertussis, B. holmesii*

☐ CRE: Carbapenemase Testing: ☐ Susceptibilities results attached.
◯ *Enterobacteriaceae* ◯ *Pseudomonas aeruginosa*
Organism name: _____

☐ CRYID: *Cryptococcus* ID

☐ DIPH: *Corynebacterium diptheriae* culture

☐ LISID: *Listeria monocytogenes* ID

☐ Other (*specify*): _____

REFERRAL TESTING / SEND-OUTS

CDC Referrals — Requires completed CDC form at: http://bitly.com/or-cdc-testing
Write in: _____

Studies
Write in: _____

ARLN Submission
Write in: _____

SELECT AGENT TESTING — Must contact the OSPHL prior to submission

☐ BURID: *Burkholderia mallei / B. pseudomallei* (*circle if known*)

☐ BACRO: *Bacillus anthracis* ☐ COXID: *Coxiella burnetii*

☐ FRAID: *Francisella tularensis* ☐ YPID: *Yersinia pestis*

☐ BRUID: *Brucella* spp.

☐ Other (*specify*): _____

PARASITOLOGY

☐ BLPAR: Blood smear for parasites (*stained slides only*)

COMMENTS / ADDITIONAL INFORMATION

Complete as many fields as possible. Required fields that will cause testing delays if not completed are marked with an asterisk (*).

GENERAL INSTRUCTIONS

Selected specimen submission clarifications are listed below for your reference. This list is not inclusive of all requirements. All specimens submitted are subject to the Oregon State Public Health Laboratory's Specimen Submission Policy, available at: http://bitly.com/SpecimenCriteria.

- Submit each specimen with a completed request form. PLEASE PRINT LEGIBLY.
- Please fill out the request form COMPLETELY or delays in processing and testing of the specimen may occur.
- Additional information beyond that on the test request form may be required, depending on the examination requested, to assure accurate and timely testing and reporting of results.
- Both the test request form and the specimen container label must have at least two matching unique identifiers. If specimen identity differs from that on the test request form, testing may not be performed!
- Specimens may be rejected for any of the following reasons:

  1. Insufficient quantity or quality;
  2. Unlabeled specimen container;
  3. Leaking specimen;
  4. Specimen with incomplete requisition;
  5. Missing or invalid ordering clinician; or
  6. Incorrect or mismatching patient identifiers.

  Every attempt will be made to salvage leaking or improperly submitted samples of cerebrospinal fluid, biopsy tissues, aspirates, and other specimens obtained surgically, providing that the safety of the laboratory worker is not compromised.