

# Microbiology/Virology Test Requisition

## Bureau of Laboratories Michigan Department of Community Health

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Technical Information 517-335-8067

Web: HTTP://www.Michigan.gov/mdchlab

Date Received at MDCH					MDCH Sample #														
<b>AGENCY - SUBMITTER INFORMATION</b>					<b>ENTER EPIC CODE/STARLIMS CODE</b>														
Return Results to:					Phone (24/7)														
					FAX														
<b>CONTACT PERSON/ REFERRING PHYSICIAN/ PROVIDER NAME</b>					<b>NATIONAL PROVIDER IDENTIFIER:</b>														
<b>PATIENT INFORMATION - NAME (LAST, FIRST, MIDDLE INITIAL OR UNIQUE IDENTIFIER) Must Match Specimen Label Exactly</b>																			
SUBMITTER'S PATIENT # - IF APPLICABLE																			
PATIENT'S CITY-RESIDENCE					ZIP CODE					GENDER		<input type="checkbox"/> Female <input type="checkbox"/> Male							
<b>RACE</b> <input type="checkbox"/> BLACK/AA <input type="checkbox"/> WHITE <input type="checkbox"/> NATIVE AMERICAN OR ALASKAN <input type="checkbox"/> ASIAN <input type="checkbox"/> HAWAIIAN/PI <input type="checkbox"/> UNKNOWN <input type="checkbox"/> OTHER (SPECIFY):																			
<b>ETHNICITY</b>		HISPANIC <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN ARAB DESCENT <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN					<b>MEDICAID or PLAN FIRST #</b>												
<b>DATE OF BIRTH</b>		M	M	D	D	Y	Y	Y	Y	<b>ONSET DATE</b>		M	M	D	D	Y	Y	Y	Y
SUBMITTER'S SPECIMEN # - IF APPLICABLE																			

**SPECIMEN INFORMATION - INDICATE TEST REQUESTED - SEE REVERSE IF NOT LISTED BELOW**

- |   |  |   |
|---|--|---|
| <b>0001</b> <input type="checkbox"/> AFB Slide/Culture-Clinical Specimen<br><b>0005</b> <input type="checkbox"/> AFB Identification - Cultural Isolate<br><b>0102</b> <input type="checkbox"/> Fungal Identification - Cultural Isolate<br><b>0200</b> <input type="checkbox"/> Aerobic Culture <u>Complete # 5 on Reverse</u><br><b>0501</b> <input type="checkbox"/> Parasitology – Stool<br><b>0601</b> <input type="checkbox"/> <i>Salmonella/Shigella</i> Serotyping-Human<br><b>0551</b> <input type="checkbox"/> Enteric Examination<br><input type="checkbox"/> Other-Specify Test Code/Name: _____ | <b>0673</b> <input type="checkbox"/> <i>C. trachomatis</i> (Non-culture) <sup>1</sup><br><b>2030</b> <input type="checkbox"/> HIV- Oral Mucosal Transudate<br><b>2100</b> <input type="checkbox"/> Syphilis (USR Test)<br><b>2107</b> <input type="checkbox"/> Syphilis TP-PA <u>(Must have prior MDCH approval)</u><br><b>2210</b> <input type="checkbox"/> Herpes Simplex Virus - Culture<br><b>2500</b> <input type="checkbox"/> Rubella IgG<br><b>2515</b> <input type="checkbox"/> Fungal Serology Comp. Fix.<br><input type="checkbox"/> Other-Specify Test Code/Name: _____ | <b>2600</b> <input type="checkbox"/> Measles IgG<br><b>2610</b> <input type="checkbox"/> Mumps IgG<br><b>2620</b> <input type="checkbox"/> Varicella Zoster IgG<br><b>2740</b> <input type="checkbox"/> HBsAg <u>Complete # 1 on Reverse</u><br><b>2745</b> <input type="checkbox"/> Hepatitis C Screen<br><b>2760</b> <input type="checkbox"/> HBS – ANTI (Anti-HBs)<br><b>2810</b> <input type="checkbox"/> Rabies AB Serology <u>Complete # on reverse</u> |
|---|--|---|

DATE COLLECTED	M	M	D	D	Y	Y	Y	Y	TIME COLLECTED					<input type="checkbox"/> A.M.	<input type="checkbox"/> P.M.
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**INDICATE SPECIMEN SOURCE BELOW**

- |                                    |  |                                 |                                  |   |                                      |
|------------------------------------|--|---------------------------------|----------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Bronchial | <input type="checkbox"/> Gastric                 | <input type="checkbox"/> Plasma | <input type="checkbox"/> Sputum  | <input type="checkbox"/> Urine                  | <input type="checkbox"/> Whole Blood |
| <input type="checkbox"/> Cervix    | <input type="checkbox"/> Nasopharyngeal          | <input type="checkbox"/> Serum  | <input type="checkbox"/> Throat  | <input type="checkbox"/> Food - Specify: _____  |                                      |
| <input type="checkbox"/> CSF       | <input type="checkbox"/> Oral Mucosal Transudate | <input type="checkbox"/> Stool  | <input type="checkbox"/> Urethra | <input type="checkbox"/> Other - Specify: _____ |                                      |

SERUM STATUS - If Applicable	<input type="checkbox"/> Acute <input type="checkbox"/> Convalescent	MDCH Prior Approval: Name, date or code _____
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**INDICATE TEST REASON BELOW**

- Diagnosis  Surveillance  Suspected Outbreak – Specify: \_\_\_\_\_
- Other – Specify: \_\_\_\_\_

- STD\*  Symptoms  Prenatal Visit  Infected Partner  Partner Risk  History of STD (< 3years)  Age recommended for Testing
- "Plan First!" Client  Medicaid other than Plan First  Retest

OUTBREAK IDENTIFIER (Foodborne ONLY - If Applicable)	ORGANISM SUSPECTED (If Applicable)
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<b>1</b>	<b>IF REQUESTING EXAMINATION FOR: HEPATITIS B TEST CODE 2740 COMPLETE ALL THAT APPLY</b>												
<input type="checkbox"/> Pregnancy (HBsAg)	<input type="checkbox"/> Exposure to someone with Hepatitis B	INFECTED PERSON'S DATE OF BIRTH				M	M	D	D	Y	Y	Y	Y
INFECTED PERSON'S NAME													
IF AN INFANT, MOTHER'S NAME													
<input type="checkbox"/> Other (Specify):										<input type="checkbox"/> Court Order		<input type="checkbox"/> At Risk	
<b>2</b>	<b>IF REQUESTING EXAMINATION FOR: SYPHILIS - DFA TEST CODE 2105 COMPLETE THIS SECTION</b>												
Duration of Lesion				<input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Years			Specify Site:						
<b>3</b>	<b>IF REQUESTING EXAMINATION FOR: RABIES ANTIBODY SEROLOGY TEST CODE 2810 COMPLETE THIS SECTION</b>												
Date of Last Rabies Vaccination		M	M	D	D	Y	Y	Y	Y				
<b>4</b>	<b>IF REQUESTING EXAMINATION FOR: LYME BORRELIOSIS TEST CODE 2111 COMPLETE THIS SECTION</b>												
ONSET DATE		M	M	D	D	Y	Y	Y	Y				
EARLY DISEASE	<input type="checkbox"/> Erythema migrans (5 cm at least in diameter)		<input type="checkbox"/> Early Disease Symptoms (Specify): (Ex., Rash, Fever, Headache, Joint Pain)										
LATE DISEASE	<input type="checkbox"/> Neurologic <input type="checkbox"/> Cardiologic <input type="checkbox"/> Rheumatologic			State/County Country of Exposure									
<b>5</b>	<b>IF REQUESTING EXAMINATION FOR: AEROBIC CULTURE TEST CODE 0200 COMPLETE ALL THAT APPLY</b>												
<input type="checkbox"/> Aerobe <input type="checkbox"/> Microaerophile    Gram <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Variable <input type="checkbox"/> Rod <input type="checkbox"/> Coccus <input type="checkbox"/> Diplococcus Bacterial Growth Char.: MacConkey <input type="checkbox"/> Pos <input type="checkbox"/> Neg    Oxidase <input type="checkbox"/> Pos <input type="checkbox"/> Neg    Catalase <input type="checkbox"/> Pos <input type="checkbox"/> Neg    Dextrose <input type="checkbox"/> Oxidation <input type="checkbox"/> Fermentation <input type="checkbox"/> Other: _____ _____ _____													

2270 ADENOVIRUS BY CULTURE  
 0004 AFB SUSCEPTIBILITY - Cultural Isolate  
 2771 ARBOVIRUS ENCEP. PANEL (IgM) §  
 0709 AUTOCLAVE TEST STRIPS  
 2145 BRUCELLA SEROLOGY  
 2230 CYTOMEGALOVIRUS CULTURE  
 2580 CYTOMEGALOVIRUS IgG  
 2400 ENTEROVIRUS BY CULTURE  
 0603 E. COLI (SLT) TOXIN & SEROLOGY  
 0701 FOODBORNE ILLNESS - Stool or Food  
 2516 FUNGAL IMMUNODIFFUSION  
 2155 FRANCISELLA SEROLOGY  
 2800 HEPATITIS A VIRUS (IgM)  
 0400 LEGIONELLA CULTURE  
 2110 LEGIONELLA - DFA  
 0402 LEGIONELLA - HA

2111 LYME DISEASE - EIA Complete # 4 Above  
 2113 LYME DISEASE-IFA (Tick or Culture)  
 0801 NEISSERIA GONORRHOEAE - Isolation  
 0851 NEISSERIA - REFERRED CULTURE  
 0502 PARASITOLOGY - BLOOD  
 0503 PARASITOLOGY - WORM  
 0750 PERTUSSIS PCR  
 2105 SYPHILIS DFA **Complete # 2 Above**  
 2103 SYPHILIS VDRL - CSF Only  
 2350 VIRAL RESPIRATORY PANEL - CULT.  
 § May - October Includes Eastern Equine, California, St. Louis and West Nile. CSF only

**The Following Tests Must Have Prior MDCH Approval**

2961 BACTERIAL TYPING - PFGE  
 0702 BOTULISM TOXIN  
 2973 ENTEROVIRUS - PCR  
 2250 MUMPS - CULTURE  
 2983 MUMPS - PCR  
 2820 MEASLES IgM @ CDC  
 4311 NOVEL INFLUENZA A - PCR  
 2951 NOROVIRUS - PCR  
 0450 PERTUSSIS CULTURE  
 2830 RUBELLA IgM  
 0602 SALMONELLA SEROTYPING (Non-Human)  
 2102 SYPHILIS FTA - ABS DS  
 2109 SYPHILIS IgM WESTERN BLOT  
 0705 TOXIC SHOCK TESTING

**\*Sexually Transmitted Diseases - Definitions**

**Symptoms:** Patient requesting examination due to symptoms, or, symptoms discovered on examination.  
**Infected Partner:** Patient has known exposure to STD (self-reported or documented).  
**Partner Risk:** Patient has multiple sex partners.  
**History of STD:** Patient has been diagnosed with a sexually transmitted disease within last 3 years.  
**Prenatal Visit:** Patient examination is part of prenatal visit.  
**Age recommended:** Recommended age criteria for screening female patients is ≤ 24 for family planning clinics, adolescent and juvenile detention sites, and all ages for STD clinics.  
**"Plan First!" Clients:** A "Plan First!" client seeking family planning services will receive screening and teaching. As a Title X Standards & Guideline requirement, *Chlamydia trachomatis* and *Neisseria gonorrhoeae* screening must be offered to "Plan First!" clients < 24 years of age, prior to provision of a contraceptive method, if risk factors are reported. CDC recommends that women testing positive for *N. gonorrhoea* and *Chlamydia trachomatis* be retested approximately 3 months after treatment. Providers are also strongly encouraged to retest all women treated for these infections whenever they seek medical care within the following 3-12 months, regardless of whether the patient believes her sex partners were treated.  
**Retest:**

<sup>1</sup>All tests positive for *Chlamydia* will automatically be tested for *N. gonorrhoeae*.