

* Required Fields

Infectious Disease Laboratory Submission Form

Submitter

*Submitting Facility: _____
*Address: _____
City: _____ State: _____ Zip: _____
Name of Person Filling Out Form: _____
Phone: _____
Originating Facility: _____
Ordering Provider: _____
Project Number if Known: _____

Patient

*Last Name: _____
*First Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Patient MRN #: _____ Sex: _____
*Date of Birth: (mm/dd/yyyy) _____ Ethnicity: _____
Race: _____

Specimen

*Submitter Sample ID: _____
*Date of Collection (mm/dd/yyyy): _____
Time of Collection (##:##): _____
AM PM

Reportable Disease/Referral

Reportable Disease Specimen (Test assigned by MDH)
Source: _____ Site: _____
CIDT Platform: _____
Organism 1: _____
Organism 2: _____
Organism 3: _____
Organism 4 / Specify Other: _____

Reportable Disease Isolate (Test assigned by MDH)
Source: _____ Site: _____
Organism: _____

Referral Testing at CDC:
CDC Test: _____

Submitting Laboratory - Specify Any Other Organism/Test Info or Comments:

Test and Epidemiology Information

Virology

Source: _____ Site: _____
Test Requested: _____
Date of Symptom Onset: _____
Vaccination Date: _____

Serology

Source: _____ Site: _____
Test Requested: _____
Date of Symptom Onset: _____
Previous Result: _____

Influenza

Source: _____ Site: _____
Test Requested: _____
Date of Symptom Onset: _____ Date of Vaccination: _____
Result/Subtype: _____ Test by Submitter: _____

Microbiology

Source: _____ Site: _____
Test Requested: _____
*Prior MDH Notification #Prior MDH Authorization

Mycobacteria

Source: _____ Site: _____
Test Requested: _____
AFB Isolate Media Submitted : _____
M.TB Complex PCR only Smear Result: _____
M.TB Complex PCR only Specimen Condition: _____

Parasitology

Source: _____ Site: _____
Test Requested: _____

Mycology

Source: _____ Site: _____
Test Requested: _____
Probe: Blasto Histo Cocci

Other

Source: _____ Site: _____
Test Requested: _____