



LIMS#: _____ Agency/Site Name: _____ Collection: Date _____ Time _____

Name: _____
(Print Clearly) (Last) (First)

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Birth Date: _____

(Check all that apply):

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black ☐ Native Hawaiian or Pacific Islander ☐ Other Race ☐ White Gender: ☐ Male ☐ Female

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown Test Reason: ☐ Screening ☐ STD contact

Insurance Name: _____ Subscriber ID: _____ Plan/Group _____

Clinician (Name and ID#): _____ ICD-10: _____

TEST REQUESTED

STD

- ☐ Chlamydia and GC DNA Amplification:
Circle Source: Cx / Urethra / Urine / Oral / Rectal/ Vaginal
- ☐ Trichomonas DNA amplification:
Circle Source: CX / Urine/ Vaginal
- ☐ Syphilis
- ☐ HIV / Confirmation
- ☐ Hepatitis C Virus
- ☐ Herpes simplex virus (HSV) / Varicella zoster virus (VZV) Source: _____

CULTURE

- ☐ Bacterial Culture -
Source: _____
(Misc., wound, genital, respiratory)
- ☐ Urine Culture
- ☐ Throat for Strep Only
- ☐ Stool Culture – Rule Out Salmonella / Shigella
- ☐ Stool Culture

AFB

- ☐ AFB Culture and Smear
Source: _____
- ☐ Mycobacteria Referral - Source: _____
- ☐ Quantiferon

DATA ENTRY BY LAB & SPECIAL REQUESTS

- ☐ Influenza rRT PCR Source: _____
- ☐ COVID-19 Source: _____
- ☐ COVID-19 Antibody Circle desired test:
IgM IgG Natural IgG Vaccine
- ☐ Respiratory Viral Panel (EPI) Source: NP Only
- ☐ Pertussis (Whooping Cough) (EPI) PCR
- ☐ Norovirus PCR (EPI)
- ☐ WNV IgM (serum or CSF)
- ☐ Syphilis – VDRL (CSF Only)
- ☐ Whole Genome Seq Source: _____
- ☐ Carbapenem Resistant Organism
Organism: _____
- ☐ Culture Independent Diagnostic
Test: _____
- ☐ Bacterial Confirmation
for: _____
- ☐ Test for / Rule out: _____
- ☐ Other: _____
Source: _____