♦ **Submitter (REQUIRED)**

♦ **LAB PROFILE Number:**

CLINICAL TEST REQUISITION
STATE OF CONNECTICUT
Dr. Katherine A. Kelley State Public Health Laboratory
395 West Street, Rocky Hill, CT 06067
CLIA ID 07D0644555
Phone 860-920-6500
Form OL-9B Rev. 01/10/2024

ACCESSION LABEL FOR CTDPH LABORATORY USE ONLY

♦ **DENOTES REQUIRED INFORMATION**

Section 1: Patient Information (*Please Print Clearly*)

♦ **Name (Last, First, M.I.) or Identifier:**

♦ **Street Address:** | ♦ **City, State, Zip:**

♦ **Date of Birth:** | Gender: ☐ Female ☐ Male ☐ Unknown | Home Phone:

Race (check all that apply): **(♦ Race/Ethnicity Information is Required for Blood Lead)**
☐ White ☐ Black/African Amer. ☐ Asian ☐ Amer. Indian/Alaska Nat. ☐ Nat. Hawaiian/Other Pacific Islander ☐ Other ☐ Unknown
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

♦ Ordering Healthcare Provider: | ♦ Phone

Section 2: Specimen Information

Specimen Storage (Prior to Delivery):
☐ Refrigerated (2-8˚C) ☐ Frozen (<-20˚C) ☐ Room Temperature
Specimen Transport/Delivery:
☐ Cold (Ice pack) ☐ Frozen (Dry Ice) ☐ Room Temperature

Specimen Receipt (*CTDPH internal use only*)
˚C
☐ Room Temperature
☐ Refrigerated
☐ Frozen

Submitter Sample ID: | ♦ **Date Collected:** | Time Collected: ☐ AM ☐ PM

♦ **Specimen Source/Type:**
☐ Axilla/groin ☐ Blood (whole) ☐ Bronchial Wash ☐ Buccal cavity ☐ Cervix ☐ CSF ☐ Lesion ☐ Nasopharynx
☐ Oropharynx ☐ Plasma ☐ Rectum ☐ Serum ☐ Sputum ☐ Stool ☐ Urethra ☐ Urine ☐ Vagina
☐ Body Fluid, specify _____ ☐ Tissue, specify _____
☐ Other, specify _____

♦ Section 3: Select Testing Requested

Bacteriology

☐ AFB Clinical Specimen (Mycobacteria Smear & Culture)
☐ AFB Referred Culture (Mycobacteria for Identification)
Bacterial Isolate for Identification **(Check one)**
☐ Group A Streptococcus ☐ Group B Streptococcus ☐ *H. influenzae*
☐ *L. monocytogenes* ☐ Legionella ☐ *N. meningitidis* ☐ *S. pneumoniae*
☐ Campylobacter ☐ *E. coli* O157 ☐ Salmonella ☐ Shigella
☐ Shiga-toxin producing *E. coli* ☐ Vibrio ☐ Yersinia
☐ Other: _____
☐ Bioterrorism Agent Identification
Specify agent: _____
Bordetella pertussis ☐ Culture ☐ DNA amplification
☐ Carbapenemase colonization screening (Rectal swab)
Carbapenem resistant organism **(Please attach susceptibility results)**
☐ Fast Track **([1]Epidemiology approval required)**
☐ CRE (Enterobacterales, specify organism) _____
☐ CRAB (*Acinetobacter baumannii*) ☐ CRPA (*Pseudomonas aeruginosa*)
☐ Enteric (Stool) Culture Suspect Organism: _____
☐ Shiga-toxin (+) Broth Culture

Blood Lead (Uninsured Patients ONLY) ♦ Race/Ethnicity Required

☐ Child Lead Screen (Capillary) ☐ Confirmation (Venous)

Mycology

☐ *Candida auris* identification (culture isolate)
☐ *Candida auris* screen
☐ Yeast ID/susceptibility testing (**Blood *Candida spp*. Isolates ONLY**)

Parasitology

☐ *Blood Parasite – Smear

Comments

Test, Agent, or Disease Not Listed (Specify):

Serology/Virology/Sexually Transmitted Infections

Arbovirus (**Please select all that apply**)
☐ *Eastern Equine Encephalitis Virus IgM Antibody
☐ *Powassan Virus IgM Antibody
☐ *West Nile/St. Louis Virus IgM Antibody
☐ Chlamydia/ Gonorrhea Nucleic Acid Amplification Test
☐ Hepatitis A Virus PCR **([1]Epidemiology approval required)**
☐ Hepatitis B Surface Antibody
☐ Hepatitis B Surface Antigen
☐ Hepatitis C Testing
☐ Herpes Simplex IgG Antibody
☐ Herpes Simplex DNA amplification
☐ HIV-1/HIV-2 Antigen/Antibody
☐ HIV Viral Load
☐ Influenza/SARS-CoV-2 multiplex PCR
☐ Measles PCR
☐ MERS CoV PCR (Novel Coronavirus) **([1]Epi Approval Required)**
☐ Mumps PCR
☐ *Non-Variola Orthopoxvirus PCR **(R/O Monkeypox Virus)**
☐ Norovirus PCR **([1]Epidemiology approval required)**
☐ QuantiFeron-TB Test **(Specify ♦ Date AND Time Collected Above)**
☐ Syphilis Screen (Serum)
☐ Syphilis VDRL (CSF)
☐ Respiratory Panel
☐ *Trichomonas vaginalis* NAAT (urine/vaginal Only)

***Please provide:**
Symptoms _____
Symptom onset date _____
Travel history _____

[1]DPH Epidemiology and Emerging Infections: (860)509-7994