Submitter Facility Name/Address	CLINICAL TEST REQUISITION STATE OF CONNECTICUT Dr. Katherine A. Kelley State Public Health Laboratory 395 West Street, Rocky Hill, CT 06067 CLIA ID 07D0644555 / CT License CL-0197 Phone 860-920-6500 **CLIENT SERVICES 860-920-6635**	***ACCESSION LABEL FOR CTDPH LABORATORY USE ONLY***
♦**LAB PROFILE Number:**		

♦ **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) ☐ Ambient Temperature

♦ **Specimen Transport/Delivery:** ☐ Cold (Ice pack) ☐ Frozen (Dry Ice) ☐ Ambient Temperature

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

♦ **Specimen Source/Type:**

☐ Blood (whole) ☐ Bronchial Wash ☐ Buccal cavity ☐ Cervix ☐ CSF ☐ Nasopharynx ☐ Oropharynx ☐ Plasma
☐ Rectal ☐ Serum ☐ Sputum ☐ Stool ☐ Urethra ☐ Urine ☐ Vaginal

☐ 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)
☐ Bioterrorism Agent Identification
specify agent:_____
☐ Bordetella pertussis (DFA, Culture) ☐ (DNA amplification)
☐ Chlamydia/ Gonorrhea Nucleic Acid Amplification Test
☐ CRE panel Organism:_____
☐ EIP Isolates for Identification **(Check one)**
☐ Group A *Streptococcus* ☐ *H. influenzae* ☐ *L. monocytogenes*
☐ *N. meningitidis* ☐ *S. pneumoniae* ☐ Other: _____
☐ Enteric Isolate for Identification
☐ *Campylobacter* ☐ *E. coli O157* ☐ *Salmonella* ☐ *Shigella*
☐ *Shiga-toxin producing E. coli* ☐ *Vibrio* ☐ Other: _____
☐ Enteric (Stool) Culture ☐ CIDT Organism: _____
☐ Shiga-toxin (+) Broth Culture

Bacterial Serology

☐ QuantiFeron-TB Test **(Specify ♦ Date & Time Collected Above)**
☐ Syphilis Screen (VDRL)
☐ Syphilis Confirmation (VDRL & TP-PA)
☐ Syphilis CSF (VDRL Only)

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

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

Mycology

☐ *Candida auris* identification

Parasitology

☐ Blood Parasite - Smear

Virology

☐ Arbovirus IgG/IgM (Encephalitis Viruses)
California Group, Eastern Equine, St. Louis, Western Equine
☐ Cytomegalovirus IgG Antibody
☐ Cytomegalovirus IgM Antibody
☐ Hepatitis B Surface Antibody
☐ Hepatitis B Surface Antigen
☐ Hepatitis C Testing
☐ Herpes Simplex IgG Antibody
☐ Herpes Simplex DNA amplification
☐ HIV-1/HIV-2 Ag/Ab
☐ HIV Viral Load
☐ Influenza PCR
☐ Measles PCR
☐ MERS CoV (Novel Coronavirus) **(Epidemiology Approval Required)**
☐ Mumps PCR
☐ Norovirus PCR **(Epidemiology Approval Required)**
☐ Respiratory Virus Antigen Panel: *Adenovirus, Human Metapneumovirus, Parainfluenza, Rhinovirus/Enterovirus, RSV*
☐ Varicella Zoster IgG Antibody
☐ West Nile Virus IgM Antibody
☐ Virus Identification (Tissue Culture)
NOTE: Zika virus testing requires submission of the Zika Virus Clinical Test Requisition

Test, Agent or Disease, Not Listed (Specify)

Comments