

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	Virology
<input type="checkbox"/> AFB Clinical Specimen (Mycobacteria Smear & Culture) <input type="checkbox"/> AFB Referred Culture (Mycobacteria for Identification) <input type="checkbox"/> Bioterrorism Agent Identification specify agent: _____ <input type="checkbox"/> Bordetella pertussis (DFA, Culture) <input type="checkbox"/> (DNA amplification) <input type="checkbox"/> Chlamydia/ Gonorrhea Nucleic Acid Amplification Test <input type="checkbox"/> CRE panel Organism: _____ <input type="checkbox"/> EIP Isolates for Identification (Check one) <input type="checkbox"/> Group A <i>Streptococcus</i> <input type="checkbox"/> <i>H. influenzae</i> <input type="checkbox"/> <i>L. monocytogenes</i> <input type="checkbox"/> <i>N. meningitidis</i> <input type="checkbox"/> <i>S. pneumoniae</i> <input type="checkbox"/> Other: _____ <input type="checkbox"/> Enteric Isolate for Identification <input type="checkbox"/> <i>Campylobacter</i> <input type="checkbox"/> <i>E. coli O157</i> <input type="checkbox"/> <i>Salmonella</i> <input type="checkbox"/> <i>Shigella</i> <input type="checkbox"/> <i>Shiga-toxin producing E. coli</i> <input type="checkbox"/> <i>Vibrio</i> <input type="checkbox"/> Other: _____ <input type="checkbox"/> Enteric (Stool) Culture <input type="checkbox"/> CIDT Organism: _____ <input type="checkbox"/> Shiga-toxin (+) Broth Culture	<input type="checkbox"/> Arbovirus IgG/IgM (Encephalitis Viruses) <i>California Group, Eastern Equine, St. Louis, Western Equine</i> <input type="checkbox"/> Hepatitis B Surface Antibody <input type="checkbox"/> Hepatitis B Surface Antigen <input type="checkbox"/> Hepatitis C Testing <input type="checkbox"/> Herpes Simplex IgG Antibody <input type="checkbox"/> Herpes Simplex DNA amplification <input type="checkbox"/> HIV-1/HIV-2 Ag/Ab <input type="checkbox"/> HIV Viral Load <input type="checkbox"/> Influenza PCR <input type="checkbox"/> Measles PCR <input type="checkbox"/> MERS CoV (Novel Coronavirus) (Epidemiology Approval Required) <input type="checkbox"/> Mumps PCR <input type="checkbox"/> Norovirus PCR (Epidemiology Approval Required) <input type="checkbox"/> Respiratory Virus Antigen Panel: <i>Adenovirus, Human Metapneumovirus, Parainfluenza, Rhinovirus/Enterovirus, RSV</i> <input type="checkbox"/> Varicella Zoster IgG Antibody <input type="checkbox"/> West Nile Virus IgM Antibody <input type="checkbox"/> Virus Identification (Tissue Culture) NOTE: Zika virus testing requires submission of the Zika Virus Clinical Test Requisition SARS-CoV-2 requires COVID-19 requisition form
Bacterial Serology <input type="checkbox"/> QuantiFeron-TB Test (Specify ◆ Date & Time Collected Above) <input type="checkbox"/> Syphilis Screen (VDRL) <input type="checkbox"/> Syphilis Confirmation (VDRL & TP-PA) <input type="checkbox"/> Syphilis CSF (VDRL Only)	Test, Agent or Disease, Not Listed (Specify) Comments
Blood Lead (Uninsured Patients ONLY) ◆ Race/Ethnicity Required <input type="checkbox"/> Child Lead Screen (Capillary Blood) <input type="checkbox"/> Lead Confirmation (Venous Blood)	
Mycology <input type="checkbox"/> <i>Candida auris</i> identification	
Parasitology <input type="checkbox"/> Blood Parasite - Smear	