

◆ Submitter (REQUIRED)

CLINICAL TEST REQUISITION
STATE OF CONNECTICUT

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Form OL-9B Rev. 03/12/2026



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) [] Room Temperature
Specimen Transport/Delivery:
[] Cold (Ice pack) [] Frozen (Dry Ice) [] Room Temperature
Specimen Receipt (CTDPH internal use only)
[] 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
Bacterial Isolate for Identification (Check one)
[] Bordetella [] Campylobacter [] E. coli O157 [] Group A Streptococcus
[] Group B Streptococcus [] H. influenzae [] Invasive E. coli
[] Legionella [] L. monocytogenes [] N. meningitidis
[] Salmonella [] Shigella [] Shiga-toxin producing E. coli
[] S. pneumoniae [] Vibrio [] Other: _____
[] Carbapenemase colonization screening (Rectal swab/Trach swab)
[] Carbapenem resistant organism (Attach susceptibility results)
[] Fast Track (1Epidemiology approval required)
[] CRE (Enterobacterales, specify organism) _____
[] CRAB (Acinetobacter baumannii) [] CRPA (Pseudomonas aeruginosa)
[] Enteric (Stool) Culture Suspect Organism: _____
[] Shiga-toxin (+) [] Broth Culture [] Stool
BioResponse
[] BioResponse Agent Identification (Please call before submission)
Specify agent: _____
Blood Lead (Uninsured Patients ONLY) ◆ Race/Ethnicity Required
[] Child Lead Screen (Capillary) [] Confirmation (Venous)
Mycobacteriology
[] AFB Clinical Specimen (Mycobacteria Smear & Culture)
[] AFB Referred Culture (Mycobacteria for Identification)
Mycology
[] Candida auris Confirmation (culture isolate from blood and/or sterile body sites)
[] 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 (1Epidemiology 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) (1Epi Approval Required)
[] Mumps PCR
[] *Non-Variola Orthopoxvirus PCR (R/O Monkeypox Virus)
[] Norovirus PCR (1Epidemiology 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 _____
1DPH Epidemiology and Emerging Infections: (860)509-7994
Evenings, weekends, holidays: (860) 509-8000