

IDAHO DEPARTMENT OF HEALTH AND WELFARE
BUREAU OF LABORATORIES

REQUEST FOR ENTERIC DISEASE TESTING

Patient Name:
Patient ID Number:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Zip Code:

Collection Date:
Date of Birth:
Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian
<input type="checkbox"/> American Indian <input type="checkbox"/> Alaskan Native
<input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other

- ONSET:** <6 hours
 6-18 hours
 18-72 hours
 >3 days
- SYMPTOMS:** Watery diarrhea
 Bloody diarrhea
 Fever
 Vomiting

Has patient received antibiotic therapy? Yes No
 Antibiotic: _____

Is this submission associated with an outbreak? Yes No
 Outbreak #: _____

Is this submission for test of cure? Yes No
 Which organism? _____

ALL SAMPLE CONTAINERS MUST BE CLEARLY MARKED WITH PATIENT IDENTIFICATION!

BACTERIAL ENTERITIS:
 Submit stool in C&S "PARA-PAK" or Cary-Blair Medium

VIRAL ENTERITIS:
 Submit stool (without preservative) or vomitus

- Enteric Screen
 - Culture for *Salmonella*
 - Culture for *Shigella*
 - Culture for *Campylobacter*
 - Culture for Shiga toxin-producing *Escherichia coli* (Including O157:H7)
- Culture for *Yersinia*
- Culture for *Aeromonas* or *Plesiomonas*
- Culture for *Vibrio*
- Other: _____

Norovirus

Send report to:

Facility: _____

Attention: _____

Address: _____

City: _____

State: _____ Zip: _____

Telephone: _____

Send copy to:

Facility: _____

Attention: _____

Address: _____

City: _____

State: _____ Zip: _____

Telephone: _____