IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

CLINICAL TEST REQUEST FORM

GENERAL INFORMATION

Patient Name/#: ______________________________ Date of Birth: _____/_____/_____ Sex: ☐ M ☐ F

Patient City and County of Residence: ______________________________ Medicaid #: ____________

Onset Date: _____/_____/_____ Collection Date: _____/_____/_____ Part of an Outbreak? ☐ No ☐ Yes (Outbreak #: ____________)

Specimen Type: ☐ Isolate ☐ Blood ☐ CSF ☐ Urine ☐ Stool ☐ Serum ☐ NP Aspirate ☐ Sputum
☐ Buccal Swab ☐ Nasal Swab ☐ NP Swab ☐ Throat Swab ☐ Other: ______________________

GENERAL IMMUNOLOGY

HIV
☐ HIV Antibody Screen
☐ Confirm HIV Rapid Test
Rapid Test Result:
____

Syphilis
☐ Routine
or ☐ Symptomatic

☐ VDRL
☐ TPPA

Hepatitis B
☐ Surface Antibody (titer)
☐ Core Antibody
☐ Surface Antigen

Hantavirus
☐ IgG/IgM

West Nile Virus
☐ IgG/IgM by EIA (serum)
Onset date required:
_____/_____/_____

Other
☐ ____________________
Prior notification required.

MYCOLOGY

☐ Fungal Identification

PARASITOLOGY

☐ Cryptosporidium/Giardia
☐ Other: ____________________

BACTERIOLOGY

Culture and ID
☐ Bacillus anthracis rule out
☐ Bacterial identification
☐ Bordetella pertussis (PCR only)
☐ Brucella rule out
☐ Burkholderia mallei/pseudomallei rule out
☐ Campylobacter spp.
☐ Coxiella burnetii rule out (PCR only)
☐ Francisella tularensis rule out
☐ Listeria
☐ Rickettsia spp.
☐ Salmonella spp.
☐ Shiga toxin-producing E.coli
☐ Shigella spp.
☐ Vibrio spp.
☐ Yersinia pestis rule out
☐ Other: ____________________

Antimicrobial Susceptibility
☐ Antimicrobial Susceptibility Confirmation
☐ Carbapenemase Resistance Testing
☐ Other: ____________________

Serotyping
☐ Group A Strep subtyping (surveillance)
☐ Haemophilus influenzae
☐ Neisseria meningitis
☐ Other: ____________________

VIROLOGY

Virology Culture
☐ Upper Respiratory Virus Panel
Influenza A&B; Parainfluenza 1,2,3; Adenovirus; Respiratory Syncytial Virus
☐ Other: ____________________

PCR
☐ Chikungunya rule out
☐ Dengue rule out
☐ Measles virus
☐ MERS coranovirus rule out
☐ Mumps virus
☐ Norovirus
☐ Orthopox virus rule out
☐ Zika virus rule out
☐ Other: ____________________

Please use Influenza Test Request form to request Influenza testing.

MYCOBACTERIOLOGY

☐ Routine Workup
☐ New Suspect
☐ Known Active Case

☐ AFB Smear and Culture
☐ AFB Identification
☐ AFB Culture Only
☐ TB NAAT
☐ Other: ____________________

REPORTING

Send report to:		**Send copy to:**	
Facility:	____________________	Facility:	____________________
Attention:	____________________	Attention:	____________________
Address:	____________________	Address:	____________________
City/State/Zip:	____________________	City/State/Zip:	____________________
Phone:	____________________	Phone:	____________________

Idaho Bureau of Laboratories • 2220 Old Penitentiary Road • Boise, ID 83712
Visit statelab.idaho.gov for Sampling and Submission Guides and Client Billing Form.

Ph: 208.334.2235
Fax: 208.334.4083

ADDITIONAL COMMENTS

SUBMISSION INSTRUCTIONS

Please attach the completed form to specimen containers. For detailed guidelines on sampling and submission, visit statelab.idaho.gov.
For use with TB testing, fold this form in fourths (fold in half twice), wrap around inner container, and insert into tube.

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