



**REQUEST FORM FOR MICROBIOLOGY & VIROLOGY TESTING**

**Submitter information:**

Clinic Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Physician or submitter name: \_\_\_\_\_

**Patient information:**

Last name: \_\_\_\_\_ First name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: Male Female

Date of Onset of Symptoms: \_\_\_\_\_ Symptoms: \_\_\_\_\_

Date of Collection: \_\_\_\_\_ Time of Collection: \_\_\_\_\_

**Type of specimen:** (check the following)

Stool \_\_\_\_ CSF \_\_\_\_  
Serum \_\_\_\_ Nasal swab \_\_\_\_  
Nasopharyngeal wash \_\_\_\_ Throat aspirate \_\_\_\_  
Urine \_\_\_\_ Wound \_\_\_\_  
Others \_\_\_\_\_

**Type of Test Requested :**

Enteric pathogens \_\_\_\_ Culture & Sensitivity \_\_\_\_  
Norovirus \_\_\_\_ West Nile Virus \_\_\_\_  
Influenza virus \_\_\_\_ Other (specify) \_\_\_\_\_  
Influenza Rapid Test Results: \_\_\_\_\_

**Specimen's storage:** Hold all specimens at 4<sup>0</sup>C or on wet ice, but not frozen if delivery to the laboratory is within 48 hours of collection.

**For H1N1specimens, please check the applicable patient condition ( X)**

< 5yrs old		>65 years		Immunosuppression	
Chronic care patient		Pregnant		Nursing home resident	
Adults and children who have chronic pulmonary, cardiovascular, hepatic, hematological, neurologic, neuromuscular, or metabolic disorder					