



# SLD CLINICAL TEST REQUEST FORM

Scientific Laboratory Division  
1101 Camino de Salud N.E.  
Albuquerque, NM 87102

SLD LAB NO. ONLY  
ONE FORM PER SPECIMEN

PLEASE PRINT LEGIBLY

SLD Form 101 v3.0

USER CODES →

<input checked="" type="checkbox"/> 51000 (Epidemiology)	<input type="checkbox"/> 52325 (PHD: Adult Hepatitis)
<input type="checkbox"/> 52000 (PHD: General)	<input type="checkbox"/> 52330 (PHD: TB Program)
<input type="checkbox"/> 52110 (PHD: Prenatal)	<input type="checkbox"/> 51006 (EIP)
<input type="checkbox"/> 52120 (PHD: Family Plan)	<input type="checkbox"/> 70704 (OMI)
<input type="checkbox"/> 52340 (PHD: Refugee)	<input type="checkbox"/> Other: (Enter Number) <input type="text"/>

Please limit to one code per form

SLD \_\_\_\_\_ DATE \_\_\_\_\_  
 USE >>> <<< TIME \_\_\_\_\_  
 ONLY \_\_\_\_\_ STAMP \_\_\_\_\_

## SUBMITTER INFORMATION PATIENT INFORMATION

SUBMITTER CODE \_\_\_\_\_  
 FACILITY NAME \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
Street or PO  
 City State Zip Code  
 PHONE ( ) \_\_\_\_\_  
 ATTENTION: \_\_\_\_\_

PATIENT NAME \_\_\_\_\_  
Last First  
 GENDER  MALE  FEMALE  TRANSGENDER  
 DATE OF BIRTH MM/ DD/ YYYY : \_\_\_\_/\_\_\_\_/\_\_\_\_  
 ADDRESS \_\_\_\_\_  
Street or PO  
 City State Zip Code  
 PATIENT ID (MRN#) \_\_\_\_\_  
 SOCIAL SECURITY \_\_\_\_\_  
 OTHER ID (HIV#) \_\_\_\_\_

CLINICIAN NAME Chad Smelser  
Last First  
 PHONE # ( 505 ) 827-0006

RACE: Check all that apply.  
 American Indian/Alaskan Native  Asian  Black/African American  
 Native Hawaiian/Pacific Islander  White  Other  
 ETHNICITY:  Hispanic  Non-Hispanic

## SPECIMEN INFORMATION

<input type="checkbox"/> Abscess	<input type="checkbox"/> Bronchial Biopsy	<input type="checkbox"/> Hair	<input type="checkbox"/> Nasal wash	<input type="checkbox"/> Sputum, nebulized
<input type="checkbox"/> Ascites fluid	<input type="checkbox"/> Bronchial Wash	<input type="checkbox"/> Fluid (site): _____	<input type="checkbox"/> Pericardial fluid	<input type="checkbox"/> Throat swab
<input type="checkbox"/> Blood, femoral	<input type="checkbox"/> Bronchoalveolar lavage	<input type="checkbox"/> Liver	<input type="checkbox"/> Peritoneal fluid	<input type="checkbox"/> Throat wash
<input type="checkbox"/> Blood, heart	<input type="checkbox"/> Cervix	<input type="checkbox"/> Lymph node	<input type="checkbox"/> Pleural fluid	<input type="checkbox"/> Tissue (site): _____
<input type="checkbox"/> Blood, plasma	<input type="checkbox"/> CSF	<input type="checkbox"/> Lung, left	<input type="checkbox"/> Pleural Biopsy	<input type="checkbox"/> Tracheal aspirate
<input type="checkbox"/> Blood, serum	<input type="checkbox"/> Ear	<input type="checkbox"/> Lung, right	<input type="checkbox"/> Rectum	<input type="checkbox"/> Urine
<input type="checkbox"/> Blood, whole	<input type="checkbox"/> Endocervix	<input type="checkbox"/> Nail (site) _____	<input type="checkbox"/> Rectum/Vagina	<input type="checkbox"/> Urethra
<input type="checkbox"/> Bone	<input type="checkbox"/> Eye	<input type="checkbox"/> Nasopharyngeal swab	<input type="checkbox"/> Skin (site) _____	<input type="checkbox"/> Vagina
<input type="checkbox"/> Bone marrow	<input type="checkbox"/> Feces/Stool	<input type="checkbox"/> Nasopharyngeal wash	<input type="checkbox"/> Spleen	<input type="checkbox"/> Wound (site): _____
<input type="checkbox"/> Brain	<input type="checkbox"/> Genital	<input type="checkbox"/> Nasal swab	<input type="checkbox"/> Sputum, natural	<input type="checkbox"/> Other: _____

<b>SPECIMEN COLLECTION</b>	<b>SPECIMEN TYPE</b>	<b>CLINICAL SYMPTOMS</b>
Date/Time Collected ____/____/____ MM/ DD/ YYYY Military Time	<input type="checkbox"/> Clinical <input type="checkbox"/> Reference	<input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic: Date of onset: MM / DD / YYYY

## ANALYSIS REQUESTED

For Details: <http://nmhealth.org/publication/view/general/1496/>

<b>BACTERIOLOGY</b> <input type="checkbox"/> B. anthracis <input type="checkbox"/> B. cereus/S. aureus <input type="checkbox"/> Culture, OMI <input type="checkbox"/> Culture, OMI anaerobic <input type="checkbox"/> Campylobacter species: _____ <input type="checkbox"/> E. coli O157:H7 <input type="checkbox"/> EIP Group A Streptococcus <input type="checkbox"/> EIP Group B Streptococcus <input type="checkbox"/> EIP S. pneumoniae isolate <input type="checkbox"/> GC culture <input type="checkbox"/> Haemophilus influenzae typing <input type="checkbox"/> Listeria monocytogenes <input type="checkbox"/> Legionella culture <b>ID of Bacteria (specify)</b> <input type="checkbox"/> Anaerobe _____ <input type="checkbox"/> Gram negative _____ <input type="checkbox"/> Gram positive _____ <b>Antimicrobial Resistance</b> (Please attach Susceptibility Report) <input type="checkbox"/> CRE Panel (Indicate below) _____ CRE: _____ _____ CRPa (P. aeruginosa) Other: _____	<input type="checkbox"/> N. meningitidis typing <input type="checkbox"/> Plague FA and culture <input type="checkbox"/> Salmonella, serotype: _____ <input type="checkbox"/> Shigella, serotype: _____ <input type="checkbox"/> Shiga Toxin test/isolation <input type="checkbox"/> Tularemia culture <input type="checkbox"/> Vibrio <input type="checkbox"/> Yersinia enterocolitica: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> Arbovirus ID <input type="checkbox"/> CDC referral (attach form 50.34) <input type="checkbox"/> HIV Ag/Ab Combo with Reflex <input type="checkbox"/> Hepatitis A Diagnosis (IgM Only) <input type="checkbox"/> Hepatitis A Immune Status <input type="checkbox"/> Hepatitis B Pre-Vaccination <input type="checkbox"/> Hepatitis B Prenatal Screen <input type="checkbox"/> Hepatitis B Post-Vaccination <input type="checkbox"/> Hepatitis B Post-Vaccination <input type="checkbox"/> Hepatitis B High Risk <input type="checkbox"/> Hepatitis B High Risk and HCV <input type="checkbox"/> Hepatitis C Antibody (Anti-HCV) <input type="checkbox"/> Other (Specify): _____	<input type="checkbox"/> Hepatitis A,B and C Diagnostic Panel (Acute) <input type="checkbox"/> Mumps Immune Status <input type="checkbox"/> Plague/Tularemia antibody <input type="checkbox"/> Rubella immune status <input type="checkbox"/> Rubella diagnosis (call first) <input type="checkbox"/> Rubeola immune status <input type="checkbox"/> Rubeola diagnosis (call first) <input type="checkbox"/> SNV Hantavirus <input type="checkbox"/> Syphilis RPR with Reflex to TPPA <input type="checkbox"/> Syphilis RPR and TPPA <input type="checkbox"/> TB Quantiferon <input type="checkbox"/> VZV immune status	
	<b>AFB/TUBERCULOSIS/MYCOLOGY</b> <input type="checkbox"/> Aerobic actinomycetes <input type="checkbox"/> AFB Culture <input type="checkbox"/> AFB Reference Isolate Suspected ID: _____ <input type="checkbox"/> Fungal/Yeast Culture <input type="checkbox"/> Fungal/Yeast Reference Isolate Suspected ID: _____	<b>MOLECULAR</b> <input type="checkbox"/> Pertussis (Bordetella sp.) PCR <input type="checkbox"/> Other: _____ (ERD only)	<input checked="" type="checkbox"/> <b>Virus Isolation</b> <b>Agent(s) suspected:</b> ___ Influenza Rapid Test: Pos ___ Neg ___ Not Performed ___ ___ HSV <input checked="" type="checkbox"/> Other (Specify): <u>norovirus</u>	<b>MOLECULAR</b> <input type="checkbox"/> Dengue/Chikungunya PCR <input type="checkbox"/> Ebola PCR <input type="checkbox"/> Other: _____ (ERD only)

Phone #'s: General Microbiology (505)383-9126/27/28; Molecular Biology (505)383-9130/60; Virology/Serology(505)383-9125/24/33; Specimen Receiving (505)383-9122; SLD Main (505)383-9000; Fax(505)383-9121