



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 v3.2 Revised 3/20

USER CODES →

| | |
|---|---|
| <input 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
 Phone Number _____
 PATIENT ID (MRN#) _____
 SOCIAL SECURITY _____
 OTHER ID (HIV#) _____

CLINICIAN NAME _____
Last First
 PHONE # () _____

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: _____ |

SPECIMEN COLLECTION SPECIMEN TYPE CLINICAL SYMPTOMS

Date/Time Collected ____/____/____ Military Time
 MM/ DD/ YYYY

Clinical Asymptomatic
 Reference Symptomatic: Date of onset: MM / DD / YYYY

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

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

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)383-9068/66 Bureau Chief (505)383-9122; SLD Man (505)383-9121