



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)	Please limit to one code per form
SLD	DATE	<input type="checkbox"/> 52000 (PHD: General)	<input type="checkbox"/> 52330 (PHD: TB Program)	
USE >>>	<<<TIME	<input type="checkbox"/> 52110 (PHD: Prenatal)	<input type="checkbox"/> 51006 (EIP)	
ONLY	STAMP	<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"/>	

SUBMITTER INFORMATION	PATIENT INFORMATION
SUBMITTER CODE _____	PATIENT NAME _____
FACILITY NAME _____	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> TRANSGENDER
ADDRESS _____ Street or PO	DATE OF BIRTH MM/ DD/ YYYY : ____/____/____
City State Zip Code	ADDRESS _____ Street or PO
PHONE () _____	PATIENT ID (MRN#) _____
ATTENTION: _____	SOCIAL SECURITY _____
	OTHER ID (HIV#) _____

CLINICIAN NAME <u>Chad Smelser</u> Last First PHONE # (505) 827-0006	RACE: Check all that apply. <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other ETHNICITY: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
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SPECIMEN INFORMATION					
S	<input type="checkbox"/> Abscess	<input type="checkbox"/> Bronchial Biopsy	<input type="checkbox"/> Hair	<input type="checkbox"/> Nasal wash	<input type="checkbox"/> Sputum, nebulized
P S	<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
E O	<input type="checkbox"/> Blood, femoral	<input type="checkbox"/> Bronchoalveolar lavage	<input type="checkbox"/> Liver	<input type="checkbox"/> Peritoneal fluid	<input type="checkbox"/> Throat wash
C U	<input type="checkbox"/> Blood, heart	<input type="checkbox"/> Cervix	<input type="checkbox"/> Lymph node	<input type="checkbox"/> Pleural fluid	<input type="checkbox"/> Tissue (site): _____
I R	<input type="checkbox"/> Blood, plasma	<input type="checkbox"/> CSF	<input type="checkbox"/> Lung, left	<input type="checkbox"/> Pleural Biopsy	<input type="checkbox"/> Tracheal aspirate
M C	<input type="checkbox"/> Blood, serum	<input type="checkbox"/> Ear	<input type="checkbox"/> Lung, right	<input type="checkbox"/> Rectum	<input type="checkbox"/> Urine
E E	<input type="checkbox"/> Blood, whole	<input type="checkbox"/> Endocervix	<input type="checkbox"/> Nail (site) _____	<input type="checkbox"/> Rectum/Vagina	<input type="checkbox"/> Urethra
N	<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 ____/____/____ MM/ DD/ YYYY Military Time	<input type="checkbox"/> Clinical	<input type="checkbox"/> Asymptomatic
	<input type="checkbox"/> Reference	<input type="checkbox"/> Symptomatic: Date of onset: MM / DD / YYYY

ANALYSIS REQUESTED

BACTERIOLOGY		AFB/TUBERCULOSIS/MYCOLOGY		SEROLOGY		MOLECULAR	
<input type="checkbox"/> B. anthracis	<input type="checkbox"/> N. meningitidis typing	<input type="checkbox"/> Aerobic actinomycetes	<input type="checkbox"/> Arbovirus ID	<input type="checkbox"/> Hepatitis A,B and C Diagnostic Panel (Acute)	<input type="checkbox"/> Hepatitis A,B and C Diagnostic Panel (Acute)	<input type="checkbox"/> Dengue/Chikungunya PCR	<input type="checkbox"/> Dengue/Chikungunya PCR
<input checked="" type="checkbox"/> B. cereus/S. aureus	<input type="checkbox"/> Plague FA and culture	<input type="checkbox"/> AFB Culture	<input type="checkbox"/> CDC referral (attach form 50.34)	<input type="checkbox"/> Mumps Immune Status	<input type="checkbox"/> Mumps Immune Status	<input type="checkbox"/> Ebola PCR	<input type="checkbox"/> Ebola PCR
<input type="checkbox"/> Culture, OMI	<input checked="" type="checkbox"/> Salmonella, serotype: _____	<input type="checkbox"/> AFB Reference Isolate	<input type="checkbox"/> HIV Ag/Ab Combo with Reflex	<input type="checkbox"/> Plague/Tularemia antibody	<input type="checkbox"/> Plague/Tularemia antibody	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Culture, OMI anaerobic	<input checked="" type="checkbox"/> Shigella, serotype: _____	<input type="checkbox"/> Suspected ID: _____	<input type="checkbox"/> Hepatitis A Diagnosis (IgM Only)	<input type="checkbox"/> Rubella immune status	<input type="checkbox"/> Rubella immune status	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
<input checked="" type="checkbox"/> Campylobacter species: _____	<input checked="" type="checkbox"/> Shiga Toxin test/isolation		<input type="checkbox"/> Hepatitis A Immune Status	<input type="checkbox"/> Rubella diagnosis (call first)	<input type="checkbox"/> Rubella diagnosis (call first)	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
<input type="checkbox"/> E. coli O157:H7	<input type="checkbox"/> Tularemia culture		<input type="checkbox"/> Hepatitis B Pre-Vaccination	<input type="checkbox"/> Rubeola immune status	<input type="checkbox"/> Rubeola immune status	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
<input type="checkbox"/> EIP Group A Streptococcus	<input type="checkbox"/> Vibrio		<input type="checkbox"/> Hepatitis B Prenatal Screen	<input type="checkbox"/> Rubeola diagnosis (call first)	<input type="checkbox"/> Rubeola diagnosis (call first)	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
<input type="checkbox"/> EIP Group B Streptococcus	<input type="checkbox"/> Yersinia enterocolitica: _____		<input type="checkbox"/> Hepatitis B Post-Vaccination	<input type="checkbox"/> SNV Hantavirus	<input type="checkbox"/> SNV Hantavirus	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
<input type="checkbox"/> EIP S. pneumoniae isolate	<input checked="" type="checkbox"/> Other: <u>C. Perfringes</u>		<input type="checkbox"/> Hepatitis B Post-Vaccination	<input type="checkbox"/> Syphilis RPR with Reflex to TPPA	<input type="checkbox"/> Syphilis RPR with Reflex to TPPA	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
<input type="checkbox"/> GC culture			<input type="checkbox"/> Hepatitis B High Risk	<input type="checkbox"/> Syphilis RPR and TPPA	<input type="checkbox"/> Syphilis RPR and TPPA	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Haemophilus influenzae typing			<input type="checkbox"/> Hepatitis B High Risk and HCV	<input type="checkbox"/> TB Quantiferon	<input type="checkbox"/> TB Quantiferon	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Listeria monocytogenes			<input type="checkbox"/> Hepatitis C Antibody (Anti-HCV)	<input type="checkbox"/> VZV immune status	<input type="checkbox"/> VZV immune status	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Legionella culture			<input type="checkbox"/> Other (Specify): _____			<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
ID of Bacteria (specify)						<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Anaerobe _____	<input type="checkbox"/> Fungal/Yeast Culture		<input type="checkbox"/> Virus Isolation			<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Gram negative _____	<input type="checkbox"/> Fungal/Yeast Reference Isolate		Agent(s) suspected:			<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Gram positive _____	<input type="checkbox"/> Suspected ID: _____		___ Influenza			<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
Antimicrobial Resistance			Rapid Test: Pos ___ Neg ___			<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
(Please attach Susceptibility Report)			Not Performed _____			<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
<input type="checkbox"/> CRE Panel (Indicate below)	<input type="checkbox"/> MOLECULAR		___ HSV			<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
___ CRE: _____	<input type="checkbox"/> Pertussis (Bordetella sp.) PCR		___ Other _____			<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
___ CRPa (P. aeruginosa)	<input type="checkbox"/> Other: _____					<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
Other: _____	<input type="checkbox"/> Other: _____					<input type="checkbox"/> Other: _____	<input type="checkbox"/> 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)383-9122; SLD Main (505)383-9000; Fax (505)383-9121