

Specimen Submission Form

STATE LABORATORY INSTITUTE

305 South Street
Jamaica Plain, MA 02130-3597
Tel. 617-983-6200

Do not use this space

PLEASE PRINT

DO NOT ABBREVIATE

1. SEND RESULTS TO :

Facility/Laboratory _____

Address _____

Phone number : () _____

2. PATIENT INFORMATION

Name _____

Address _____

Phone () _____

Patient ID _____

3. ORDERING PHYSICIAN/CONTACT - Name

Phone Number: () _____

5. TEST REQUESTED:

Reason: Symptomatic Test of Cure Surveillance
 Confirmation Contact

Presumptive ID: _____

For: Identification Isolation Typing
(-----Complete Section 7-----)

Serology (Complete Section 6)

Other (specify) _____

4. Sex M F Other

Date of Birth

____/____/____

Ethnicity

Hispanic or Latino Not Hispanic or Latino

Race

(check one)

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Other

6. SEROLOGY:

Serum Spinal Fluid

Acute Convalescent Late Convalescent

Date Collected ____/____/____

7. CULTURE: Specimen submitted is: (Please check one and complete date collected or date of subculture)

Original Material. Date Collected: ____/____/____ Subculture. Date Subculture made: ____/____/____

Has specimen been treated? Yes No Specify Method _____

Source of Specimen:

- | | | | |
|--------------------------------------|---------------------------------------|--|---|
| <input type="checkbox"/> Anal Canal | <input type="checkbox"/> Pharynx | <input type="checkbox"/> Throat | <input type="checkbox"/> Wound (site) |
| <input type="checkbox"/> Blood | <input type="checkbox"/> Plasma | <input type="checkbox"/> Urethra | |
| <input type="checkbox"/> Bone marrow | <input type="checkbox"/> Serum | <input type="checkbox"/> Urine | <input type="checkbox"/> Exudate (site) |
| <input type="checkbox"/> Cervix | <input type="checkbox"/> Spinal Fluid | | |
| <input type="checkbox"/> Gastric | <input type="checkbox"/> Sputum | <input type="checkbox"/> Body Fluid (site) | <input type="checkbox"/> Tissue (specify) |
| <input type="checkbox"/> Nasopharynx | <input type="checkbox"/> Stool | | |
| | | <input type="checkbox"/> Bronchus (site) | <input type="checkbox"/> Other (specify) |

8. FOR VIRUS SEROLOGY, VIRUS ISOLATION and TESTS LISTED AS CDC SEROLOGY or CDC CULTURE IN THE SLI MANUAL OF TESTS and SERVICES.

Symptoms, Date of Onset and Duration _____

Travel History (and dates of travel) _____

Animal/Arthropod Contact (specify) _____

Previous Laboratory Results _____

Relevant Immunizations (give dates) _____

Additional Information: _____

INSTRUCTIONS: If a section does not apply to a given situation, write N/A (not applicable). For more information on SLI testing, see the SLI Manual of Tests and Services at <http://www.mass.gov/dph/bls/>