

Explanation of changes for MTPHL request form:

PATIENT INFORMATION (please PRINT legibly)	FACILITY/PROVIDER INFORMATION
LAST NAME <input type="text"/>	FACILITY ACCOUNT #/ADDRESS <input type="text"/>
FIRST NAME <input type="text"/>	
SUBMITTER PATIENT ID/ MEDICAL RECORD NUMBER <input type="text"/> (1)	PATIENT ZIP CODE <input type="text"/> (2)
DATE OF BIRTH <input type="text"/> / <input type="text"/> / <input type="text"/>	PHYSICIAN: LAST NAME, FIRST NAME <input type="text"/> (4)
GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Trans M>F <input type="checkbox"/> Female <input type="checkbox"/> Trans F>M <input type="checkbox"/> Undisclosed	NATIONAL PROVIDER IDENTIFIER (NPI) <input type="text"/>
Medicaid / Medicare Billing Information: <input type="checkbox"/> Bill MEDICAID <input type="checkbox"/> Inpatient <input type="checkbox"/> Bill MEDICARE <input type="checkbox"/> Outpatient MEDICAID or MEDICARE NUMBER <input type="text"/>	MTPHL USE ONLY <input type="text"/>
ICD Diagnosis Codes: <input type="text"/> (3)	

(1) Please use the patient’s unique identifier (this should be the same every time a facility sends a sample, in order that we do not have duplicate records in our LIS).

(2) We have removed the patient’s address, but are still are requesting their zip code, which is important for surveillance purposes.

(3) Diagnosis codes are REQUIRED for Medicaid/Medicare billing purposes.

(4) Please write the provider’s FIRST and LAST name so we are sure to select the correct one.

SPECIMEN DETAILS
SUBMITTER SPECIMEN ID/ACCESSION # <input type="text"/> (5)
SPECIMEN COLLECTION DATE <input type="text"/> / <input type="text"/> (6) / <input type="text"/>
DATE OF ONSET (if applicable) <input type="text"/> / <input type="text"/> (7) / <input type="text"/>
Please call 1-800-821-7284 for more forms
DO NOT PHOTOCOPY

(5) You may put your laboratory specimen ID or accession number in this part of the form.

(6) Please annotate the date the specimen was collected.

(7) The date of onset is required for any symptoms that are applicable to diagnosis.

Other Test(s) Requested/ Pertinent Information / Comments

COVID-19

We have added an order choice for COVID-19 in the comments section. Please enter any other comments here as well as before.

We've added some tests and deleted others in the various sections. Note that some of the tests previously under "Micro Surveillance" have been moved to the "Reference Microbiology" section. Yeast for antimicrobial resistance has been added to the "Mycology/Parasitology" section, and quantitative HIV and HCV have been added to the "Molecular" section.

Reference Microbiology:

- Bacteriology Culture/ID, Aerobic
- Bacteriology Culture/ID, Anaerobic
- BT Agent Rule Out (list in Comments)
- E. Coli O157:H7 Screen
- EHEC (STEC) Toxin Test
- Enteric Panel Culture, includes EHEC
- ESBL Confirmation
- Legionella Direct Detection/Culture/ID
- MRSA Confirmation
- Neisseria gonorrhoeae Culture/ID
- Salmonella/Shigella Test of Cure
- Vibrio screen
- VRE Confirmation
- Yersinia screen

Mycology/Parasitology:

- Fungal Culture/ID
- Modified Acid Fast Stain
- Cryptosporidium/Cyclospora Detection
- Malaria/Blood Parasite Screen
- *call before sending*
- Ova and Parasite Exam
- Yeast ARLN Study

Molecular:

- Hepatitis C RNA Quantitation
- Herpes Simplex I/II (Aptima)
- HIV RNA Quantitation (Plasma only)

We've added specimen sources and re-arranged them alphabetically to make them easier to find.

- | | |
|--|--|
| <input type="checkbox"/> Autoclave QC Vial | <input type="checkbox"/> Stimulated Plasma (QFT) |
| <input type="checkbox"/> Biopsy (specify below) | <input type="checkbox"/> Stool |
| <input type="checkbox"/> Blood-Heparinized | <input type="checkbox"/> Swab-Buccal |
| <input type="checkbox"/> Blood-EDTA (Capillary) | <input type="checkbox"/> Swab-Endocervical |
| <input type="checkbox"/> Blood-EDTA (Venous) | <input type="checkbox"/> Swab-Lesion (specify below) |
| <input type="checkbox"/> Blood (for culture) | <input type="checkbox"/> Swab-Nasal |
| <input type="checkbox"/> Bronchial Alveolar Lavage | <input type="checkbox"/> Swab-Nasopharyngeal |
| <input type="checkbox"/> Bronchial Washings | <input type="checkbox"/> Swab-Rectal |
| <input type="checkbox"/> CSF | <input type="checkbox"/> Swab-Throat |
| <input type="checkbox"/> Fluid-Pleural | <input type="checkbox"/> Swab-Urethral |
| <input type="checkbox"/> Fluid (specify below) | <input type="checkbox"/> Swab-Vaginal |
| <input type="checkbox"/> Nasal Washings | <input type="checkbox"/> Tissue-Lung |
| <input type="checkbox"/> Plasma | <input type="checkbox"/> Tissue (specify below) |
| <input type="checkbox"/> Serum | <input type="checkbox"/> Urine |
| <input type="checkbox"/> Sputum | <input type="checkbox"/> Other _____ |

Additional specimen details/source site