

# MONTANA DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

## Public Health Laboratory Request Form

P.O. Box 4369, Helena, MT 59604-4369  
(406) 444-3444 (800) 821-7284 CLIA ID # 27D0652531

DPHHS.PHL 0117

### PATIENT INFORMATION (please PRINT legibly)

LAST NAME											
FIRST NAME											
SUBMITTER PATIENT ID/ MEDICAL RECORD NUMBER						PATIENT ZIP CODE					
DATE OF BIRTH				GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans M>F <input type="checkbox"/> Trans F>M <input type="checkbox"/> Undisclosed							
Medicaid / Medicare Billing Information:						ICD Diagnosis Codes:					
<input type="checkbox"/> Bill MEDICAID		<input type="checkbox"/> Inpatient		<input type="checkbox"/> Bill MEDICARE		<input type="checkbox"/> Outpatient					
MEDICAID or MEDICARE NUMBER											

### FACILITY/PROVIDER INFORMATION

FACILITY ACCOUNT #/ADDRESS											
PHYSICIAN: LAST NAME, FIRST NAME											
NATIONAL PROVIDER IDENTIFIER (NPI)											

### MTPHL USE ONLY

### TEST(S) REQUESTED INFORMATION

<p><b>Serology:</b></p> <input type="checkbox"/> Blood Lead <input type="checkbox"/> Brucella Antibody <input type="checkbox"/> Colorado Tick Fever IgG <input type="checkbox"/> Fungal Serology <input type="checkbox"/> Hantavirus IgM Serology <input type="checkbox"/> Hepatitis - Acute Panel <input type="checkbox"/> Hepatitis A IgM Antibody <input type="checkbox"/> Hepatitis B Surface Antigen <input type="checkbox"/> Hepatitis B Surface Antibody <input type="checkbox"/> Hepatitis B Total Core Antibody <input type="checkbox"/> Hepatitis B Core IgM Antibody <input type="checkbox"/> Hepatitis C Ab with Reflex Confirmation <input type="checkbox"/> Herpes Simplex Virus IgG Serology <input type="checkbox"/> HIV Ab/Ag Combo with Reflex Confirmation <input type="checkbox"/> HIV Confirmation (Geenius) <input type="checkbox"/> Lyme Total Abs with Reflex Confirmation <input type="checkbox"/> Measles (Rubeola) IgG <input type="checkbox"/> Mumps IgG Serology <input type="checkbox"/> Q Fever IgG Serology <input type="checkbox"/> Rocky Mtn Spotted Fever IgG <input type="checkbox"/> Rubella IgG <input type="checkbox"/> Syphilis Screen with Reflex Confirmation <input type="checkbox"/> Syphilis Titer Only <input type="checkbox"/> TB - QuantiFERON Gold In-Tube Testing <p><b>Time Collected:</b> Incubated 16 - 24 hrs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <input type="checkbox"/> Tick Borne Disease Panel + Lyme <input type="checkbox"/> Tularemia Antibody <input type="checkbox"/> Varicella Zoster Virus IgG <input type="checkbox"/> West Nile Virus IgG <input type="checkbox"/> West Nile Virus IgM <input type="checkbox"/> Other Serology (Indicate in comments)	<p><b>Sterilizer Monitoring:</b></p> <input type="checkbox"/> Autoclave Monitoring - Q/C Test <p><b>Micro Surveillance:</b></p> <p>Organism: _____</p> <input type="checkbox"/> Carbapenem Resistant Enterobacteriaceae <input type="checkbox"/> Carbapenem Resistant Pseudomonas <input type="checkbox"/> Neisseria gonorrhoeae Confirmation <input type="checkbox"/> Neisseria meningitidis Confirmation <input type="checkbox"/> Haemophilus influenzae Confirmation <input type="checkbox"/> Salmonella/Shigella/E. coli/Campy <input type="checkbox"/> Vibrio Confirmation <input type="checkbox"/> Yersinia Confirmation <input type="checkbox"/> Other Confirmation (indicate in comments)	<p><b>Reference Microbiology:</b></p> <input type="checkbox"/> Bacteriology Culture/ID, Aerobic <input type="checkbox"/> Bacteriology Culture/ID, Anaerobic <input type="checkbox"/> BT Agent Rule Out (list in Comments) <input type="checkbox"/> E. Coli O157:H7 Screen <input type="checkbox"/> EHEC (STEC) Toxin Test <input type="checkbox"/> Enteric Panel Culture, includes EHEC <input type="checkbox"/> ESBL Confirmation <input type="checkbox"/> Legionella Direct Detection/Culture/ID <input type="checkbox"/> MRSA Confirmation <input type="checkbox"/> Neisseria gonorrhoeae Culture/ID <input type="checkbox"/> Salmonella/Shigella Test of Cure <input type="checkbox"/> Vibrio screen <input type="checkbox"/> VRE Confirmation <input type="checkbox"/> Yersinia screen
<p><b>Molecular:</b></p> <input type="checkbox"/> Adenovirus PCR <input type="checkbox"/> Bordetella pertussis multitarget PCR <input type="checkbox"/> C difficile/NAP1 PCR <input type="checkbox"/> Chlamydia (Aptima) <input type="checkbox"/> Chlamydia/Gonorrhea (Aptima) <input type="checkbox"/> Enterovirus PCR <input type="checkbox"/> Enterovirus D68 PCR <input type="checkbox"/> Gonorrhea (Aptima) <input type="checkbox"/> Hepatitis C RNA Quantitation <input type="checkbox"/> Herpes Simplex I/II (Aptima) <input type="checkbox"/> HIV RNA Quantitation (Plasma only) <input type="checkbox"/> Influenza A and B PCR <input type="checkbox"/> Influenza Surveillance <input type="checkbox"/> Measles (Rubeola) PCR <input checked="" type="checkbox"/> Mumps PCR <input type="checkbox"/> Norovirus PCR <input type="checkbox"/> Varicella Zoster PCR	<p><b>TB/Mycobacteriology:</b></p> <input type="checkbox"/> TB Mycobacteria Smear/Culture/ID <input type="checkbox"/> M. tuberculosis NAAT (Molecular) <i>(Should be ordered on all highly suspect specimens)</i>	<p><b>Mycology/Parasitology:</b></p> <input type="checkbox"/> Fungal Culture/ID <input type="checkbox"/> Modified Acid Fast Stain <input type="checkbox"/> Cryptosporidium/Cyclospora Detection <input type="checkbox"/> Malaria/Blood Parasite Screen <i>- call before sending</i> <input type="checkbox"/> Ova and Parasite Exam <input type="checkbox"/> Yeast ARLN Study
<p><b>Zika Testing</b> (Is the patient pregnant? Y / N )</p> <input type="checkbox"/> Zika Triplex PCR Serum <input type="checkbox"/> Zika Triplex PCR Serum/Urine Combo <i>(Triplex PCR Includes Dengue and Chikungunya)</i>		

### SPECIMEN DETAILS

SUBMITTER SPECIMEN ID/ACCESSION #											
SPECIMEN COLLECTION DATE											
DATE OF ONSET (if applicable)											

Please call 1-800-821-7284 for more forms

DO NOT PHOTOCOPY

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

### Other Test(s) Requested/ Pertinent Information / Comments

COVID-19

20872

