OFFICE OF LABORATORY SERVICES
167 11th Avenue | South Charleston, WV 25303
PH: (304) 558-3530 | FX: (304) 558-2006

PLACE BARCODE HERE

OLS USE ONLY

MICROBIOLOGY LABORATORY SPECIMEN SUBMISSION FORM

PATIENT INFORMATION

PATIENT ID (Chart #, etc.) *MAX. 17 CHARACTERS*		
LAST NAME	FIRST NAME	MI
DATE OF BIRTH	SS# *(last 4 only, optional)*	
COUNTY OF RESIDENCE	SEX (at birth) ❑ Female ❑ Male	
STREET ADDRESS		
CITY	STATE	ZIP
PATIENT PHONE NO. *(optional)*		
RACE ❑ White ❑ Asian ❑ Black ❑ Other ❑ American Indian/Alaskan ❑ Unknown ❑ Native Hawaiian or other Pacific Islander	ETHNICITY ❑ Not Hispanic or Latino ❑ Hispanic or Latino ❑ Unknown	

SUBMITTER INFORMATION

THE INFORMATION BELOW IS FOR THE MAILING OR FAXING OF TEST REPORTS. PLEASE MAKE SURE THE MAILING ADDRESS AND FAX NUMBER ARE ACCURATE.

FACILITY NAME		
MAILING ADDRESS (*NO P.O. BOX*)		
CITY	STATE	ZIP
COUNTY		
ATTENTION TO		
PHONE NO.		
FAX NO.		

COMMENTS:

DATE OF COLLECTION:

SITE / SOURCE OF SPECIMEN:

❑ Blood	❑ Sputum
❑ CSF	❑ Sputum, induced
❑ Nasopharyngeal	❑ Stool
❑ Urine	❑ Stool, bloody
❑ Rectal	❑ Throat
❑ Serum	❑ Urethra
❑ Serum, acute	❑ Cellulose tape mount
❑ Serum, convalescent	
❑ Wound Location:	
❑ Bronchial Specify:	
❑ Tissue Specify:	
❑ Fluid Specify:	
❑ Other Specify:	

TEST(S) REQUESTED:

BACTERIOLOGY

- ❑ Referred Culture
- ❑ Pertussis culture / PCR
- ❑ Enteric (stool in Cary-Blair)
- ❑ Gonorrhea culture
- ❑ Unknown bacterial ID

Suspected Organism (s):

MOLECULAR

GI PATHOGENS

- ❑ Norovirus RT-PCR ***
- ❑ GI Pathogen Panel ***

RESPIRATORY PATHOGENS

- ❑ Respiratory Pathogen Panel ***
- ❑ Influenza RT-PCR

Submitted For:
❑ Surveillance ❑ Outbreak
❑ Unsubtypeable Influenza A

Optional Respiratory Specimen Data
Symptom Onset Date: / /
Patient Level of Care:
❑ Inpatient ❑ Outpatient
Was specimen pre-screened?
❑ Yes (specify under Comments)
❑ No

MYCOBACTERIOLOGY

- ❑ Culture / Smear C
- ❑ TB ID / Confirmation R
- ❑ NTM Identification R

Suspected Organism:

Date growth appeared:

Patient taking TB drugs?
❑ Yes ❑ No
Date Started:

Skin Test
❑ POS (+) ❑ NEG (-)

Chest X-ray
❑ Abnormal ❑ Normal

Contact to TB patient?
❑ Yes ❑ No

Refrigerated? ❑ Yes ❑ No

PARASITOLOGY

- ❑ Fecal Parasite Exam (10% Formalin)
- ❑ Pinworm Exam (cellulose tape mount)

SENDOUT

- ❑ Referral Testing / ID

REFERENCE

- ❑ ARLN Reference DST

****** Testing performed on outbreak specimens ONLY.***

DIDE = Division of Infectious Disease Epi

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❑ UNSAT | Reason:	ACC:
❑ UNRELIABLE | Reason:	DE:
❑ SATISFACTORY	CKD:

OUTBREAK NUMBER

(REQUIRED FOR OUTBREAKS - OBTAIN FROM DIDE)

CONTACT NAME:

FAILURE TO COMPLETE THIS FORM IN ITS ENTIRETY MAY RESULT IN DELAYED TEST RESULTS

rev. 02/2022