



**SC DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
PUBLIC HEALTH LABORATORY
8231 Parklane Road Columbia, SC 29223
(803) 896-0800
CLIA # 42D0658606**

Date Received
PHL Specimen Number

Patient's Name (Last)		(Suffix)	(First)		(MI)	Sex	Ethnicity	Race <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Date of Birth MO DAY YR		
Address				City	State	Zip Code	County of Residence			Phone Number			
MCI Number				Local ID	Clinic ID			Program Number	Country of Birth				
(CHD CLIENTS ONLY) Sender Number				Billing Number			Outbreak #						
Sender Address						ORDERING PHYSICIAN, PROVIDER AND/OR NURSE:							
						Special Instructions and/or Comments:							
SPECIMEN INFORMATION						Date of Onset: ____/____/____							
MO	Collection Date DAY YR		Collection Time		Initial		Agents/Organisms/or Virus suspected:						
			__AM ()				Clinical Diagnosis:						
			__PM				SYMPTOMS						
Specimen Type/Source						__ Asymptomatic __ Encephalitis __ Pleurodynia __ Arthralgia/Myalgia __ Fever __ Rash _____ Type __ Conjunctivitis __ Meningitis __ Respiratory __ Diarrhea __ Nausea/Vomiting __ Other: _____							
__ 07 BAL		__ 65 Smear*											
__ 01 Blood		__ 08 Sputum		specify									
__ 28 Bronchial wash		__ induced											
__ 03 CSF		__ spontaneous											
__ 14 Eye		__ 13 Throat Swab											
__ 10 Feces		__ 12 Tissue/Biopsy		specify									
__ 34 Fluid		__ 04 Urine											
specify		__ 32 Wound/Pus/Drainage											
__ 23 Genital		__ 33 Enteric Transport Media											
specify		__ 34 Test of Cure											
__ 52 Nasopharyngeal Swab		__ 99 Other		specify									
__ 60 Sinus													
specify													
						*Do not mark for TB samples							

TEST REQUESTED

CLINICAL MICROBIOLOGY (BACTERIOLOGY)				VIROLOGY			
Was culture incubated before Transport: __No __Yes: __24 hrs. __48 hrs.				SHIP ALL SPECIMENS FOR ISOLATION COLD			
__501 GC Culture & ID __502 Culture/Isolate for Shiga toxin producing E. coli __503 Broth/Specimen for Shiga toxin producing E. coli __508 Enteric Culture		__510 Non-Enteric Culture & ID __511 Organism for ID- aerobic __512 Legionella Urine Antigen Test __513 BioFire FilmArray GI panel __515 CRE/CRPA/CRAB List organism _____ __Other _____ specify		__114 Norovirus Detection by RT-PCR __115 Bordetella Multiplex by RT-PCR __121 GI Outbreak __250 Herpes Culture (_____ Disease Active) __270 Routine Viral Culture		__271 Influenza RT-PCR __273 Mumps RT-PCR __274 Measles RT-PCR __275 CDC Trioplex RT-PCR __276 BioFire Respiratory Panel (outbreak investigations only)	
MYCOBACTERIOLOGY				SPECIAL PATHOGENS		MOLECULAR	
__601 Clinical Specimen for ID and smear __602 Isolate for ID __604 Drug Susceptibility __ Clinical Specimen __ Referred Isolate __605 QuantiFeron TB-Gold Incubation: start time _____ end time _____		Known TB case? Y N R/O new TB case? Y N Suspicious hx, s/sx? Y N Current Rx? Y N		__520 Rule-out Testing: __Bacterial Isolate __ Clinical Specimen Suspect Agent: _____ __521 Molecular Testing for Viral Agents: __Influenza A: H5/H7 __MERS __Ebola __Other __522 Serological Testing: __BMAT __Malaria		__120 PFGE Subtyping __ Other _____ _____ Specify	
CLINICAL MICROBIOLOGY (PARASITOLOGY)				PHL USE ONLY			
__406 Cryptosporidium Antigen		__410 Other _____ Specify		:			

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INSTRUCTIONS FOR COMPLETING REQUEST FORM
DHEC 1335

(May use printed patient lab label)

1. Enter patient name.
2. Write M = Male; F = Female or TX = Transgender M2F (Male to Female); or TY = F2M (Female to Male) in Sex box.
3. Enter ethnicity as follows: H = Hispanic/Latino and N = NonHispanic/Latino.
4. Enter race as follows:

A = Asian	B = Black/African American
W = White	I = American Indian/Alaskan Native
P = Native Hawaiian/ Other Pacific Islander	O = Other
	U = Unknown/Unclassified
5. Enter date of birth (month, day and year.) Example: enter 03/06/1960 for the birthday March 6, 1960.
6. Enter the patient address and five-digit zip code.
7. Enter county of residence and the 10-digit telephone number.
8. Fill in patient MCI ID number (DHEC Clients only).
9. Enter local and clinic ID if applicable. (Private clients must provide a clinic ID)
10. Enter Program number.
11. Enter Country of Birth.
12. Enter billing number if billing number is different from sender number.
13. Enter the Outbreak number.
14. Enter the date and time of collection and initial.
15. Check type/source of specimen.
16. Enter Ordering Physician, Provider and/or Nurse if applicable. **Note: Please print.**
17. Enter in the Special Instructions and/or comments where you vacated (travel history).
18. Enter Date of Onset if applicable.
19. List agents, organisms, or virus suspected.
20. Enter clinical diagnosis.
21. Check symptoms that apply.
22. Mark test requested.
23. Answer the four questions in Mycobacteriology Section.
24. Send top two copies of the form with the specimen(s) to the lab. **PLEASE RETAIN THIRD COPY FOR YOUR RECORDS.**