



**DHEC 1335 Submission Form**  
 DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL  
 Public Health Laboratory  
 8231 Parklane Road Columbia, SC 29223  
 (803) 896-0800

CLIA#42D0658606

**ALIGN BARCODE LABEL  
TO TOP OF BOX**

Patient's Name (Last)		(First)	(MI)	Sex	Ethnicity	Race	Date of Birth	
Address			City	State	Zip Code	County of Residence		
Phone Number		Country of Birth		MCI Number		Local ID		Clinic ID
Sender No.	Sender Name			Billing Number	Program No.	Outbreak Number		
Ordering Physician, Provider and/or Nurse:				Clinical Diagnosis				
Special Instructions and/or Comments:								
<b>Specimen Information</b>				<b>Date of Onset</b>		<b>Agents/Organisms/or Virus Suspected</b>		
Collection Date:		Collection Time:						
				<input type="checkbox"/> AM <input type="checkbox"/> PM				
<b>Specimen Type/Source</b>								
<input type="checkbox"/> Blood/Serum <input type="checkbox"/> Bronchial wash <input type="checkbox"/> Nasopharyngeal Swab <input type="checkbox"/> Smear (Do not mark for TB) <input type="checkbox"/> Stool specimens		<input type="checkbox"/> Throat swab <input type="checkbox"/> Urine <input type="checkbox"/> Wound pus drainage <input type="checkbox"/> BAL <input type="checkbox"/> Swab _____		<input type="checkbox"/> Genital _____ <input type="checkbox"/> Tissue/Biopsy _____ <input type="checkbox"/> Other _____		<b>Mycobacteriology Specimens</b> <input type="checkbox"/> Induced sputum <input type="checkbox"/> Spontaneous sputum <input type="checkbox"/> Other _____		
<b>Symptoms</b>								
<input type="checkbox"/> Arthralgia/Myalgia <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Conjunctivitis		<input type="checkbox"/> Diarrhea <input type="checkbox"/> Encephalitis <input type="checkbox"/> Fever		<input type="checkbox"/> Meningitis <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Pleurodynia		<input type="checkbox"/> Rash Type: _____ <input type="checkbox"/> Respiratory <input type="checkbox"/> Other		
<b>Test Requested</b>								
<b>Clinical Microbiology (Bacteriology/Parasitology)</b>								
Was culture incubated before transport: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 24 hours <input type="checkbox"/> 48 hours								
<input type="checkbox"/> Broth Specimen for Shiga toxin producing E. coli <input type="checkbox"/> CRE/CRPA/CRAB <input type="checkbox"/> Candida ID <input type="checkbox"/> Cryptosporidium Antigen		<input type="checkbox"/> Culture/Isolate for Shiga toxin producing E. coli <input type="checkbox"/> Enteric Culture <input type="checkbox"/> GC Culture and ID		<input type="checkbox"/> Legionella Urine Antigen <input type="checkbox"/> Non-Enteric Culture and ID <input type="checkbox"/> Organism for ID-Aerobic <input type="checkbox"/> Other _____				
<b>Mycobacteriology</b>								
Known TB case? <input type="checkbox"/> Yes <input type="checkbox"/> No		R/O new TB Case? <input type="checkbox"/> Yes <input type="checkbox"/> No		Suspicious hx, s/sx? <input type="checkbox"/> Yes <input type="checkbox"/> No		Current Rx? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Clinical Specimen for ID and Smear <input type="checkbox"/> Isolate for ID <input type="checkbox"/> Blood Culture		<input type="checkbox"/> Drug Susceptibility: <input type="checkbox"/> Clinical Specimen <input type="checkbox"/> Referred Isolate		<input type="checkbox"/> Specimen for Genotyping				
<b>Virology</b>								
<input type="checkbox"/> BioFire Respiratory Panel (Outbreak Only) <input type="checkbox"/> Bordetella (BioFire) <input type="checkbox"/> GI Outbreak (Norovirus RT-PCR and/or Biofire GI panel) <input type="checkbox"/> Influenza RT-PCR In-patient Out-Patient <input type="checkbox"/> QuantiFeron TB-Gold Plus Incubation Start Time:		<input type="checkbox"/> Herpes <input type="checkbox"/> Measles RT-PCR <input type="checkbox"/> Mumps RT-PCR <input type="checkbox"/> Triplex RT-PCR End Time:		COVID RT-PCR First Test?		Y N U Hospitalized?		Y N U
				Employed in healthcare?		ICU?		Y N U
				Symptomatic (CDC defined)?		Pregnant?		Y N U
				Resident in a congregate care facility?				Y N U
<b>Special Pathogens</b>								
<b>Rule-out Testing</b>			<b>Molecular Testing for Viral Pathogens</b>			<b>Serological Testing</b>		
<input type="checkbox"/> Bacterial Isolate <input type="checkbox"/> Clinical Specimen Suspect Agent: _____			<input type="checkbox"/> Avian Influenza <input type="checkbox"/> Ebola <input type="checkbox"/> MERS <input type="checkbox"/> Other			<input type="checkbox"/> BMAT <input type="checkbox"/> Malaria		



# INSTRUCTIONS FOR COMPLETING REQUEST FORM DHEC 1335

*(May use printed patient lab label)*

1. Enter patient name.
2. Enter M = Male; F = Female; 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 one copy of the form with the specimen(s) to the lab. **PLEASE RETAIN AN ADDITIONAL COPY FOR YOUR RECORDS.**

Request forms will be retained following DHEC records retention schedule 8581, "Requests for Laboratory Analysis", Records Group Number: 169.