1335 Submission Form

DEPARTMENT OF PUBLIC HEALTH
Public Health Laboratory
8231 Parklane Road Columbia, SC 29223
(803) 896-0800

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:

Specimen Information		Date of Onset	Agents/Organisms/or Virus Suspected
Collection Date:	**Collection Time:** ☐AM ☐PM		

Specimen Type/Source

☐ Blood/Serum
☐ Bronchial wash
☐ Nasopharyngeal Swab
☐ Smear (Do not mark for TB)
☐ Stool specimens
☐ Throat swab
☐ Urine
☐ Wound pus drainage
☐ BAL
☐ Swab _____
☐ Genital_____
☐ Tissue/Biopsy_____
☐ Other _____

Mycobacteriology Specimens
☐ Induced sputum
☐ Spontaneous sputum
☐ Other_____

Symptoms

☐ Arthralgia/Myalgia
☐ Asymptomatic
☐ Conjunctivitis
☐ Diarrhea
☐ Encephalitis
☐ Fever
☐ Meningitis
☐ Nausea/Vomiting
☐ Pleurodynia
☐ Rash Type: _____
☐ Respiratory
☐ Other

Test Requested

Clinical Microbiology (Bacteriology/Parasitology)

Was culture incubated before transport: ☐ Yes ☐ No ☐ 24 hours ☐ 48 hours

☐ Broth Specimen for Shiga toxin producing E. coli
☐ CRE/CRPA/CRAB
☐ Candida ID
☐ Cryptosporidium Antigen
☐ Culture/Isolate for Shiga toxin producing E. coli
☐ Enteric Culture
☐ GC Culture and ID
☐ Legionella Urine Antigen
☐ Non-Enteric Culture and ID
☐ Organism for ID-Aerobic
☐ Other_____

Mycobacteriology

Known TB case? ☐ Yes ☐ No | R/O new TB Case? ☐ Yes ☐ No | Suspicious hx, s/sx? ☐ Yes ☐ No | Current Rx? ☐ Yes ☐ No

☐ Clinical Specimen for ID and Smear
☐ Isolate for ID ☐ Blood Culture
☐ Drug Susceptibility:
☐ Clinical Specimen ☐ Referred Isolate
☐ Specimen for Genotyping

Virology

☐ BioFire Respiratory Panel (Outbreak Only)
☐ Bordetella (BioFire)
☐ GI Outbreak (Norovirus RT-PCR and/or Biofire GI panel)
☐ Influenza RT-PCR ☐ In-patient ☐ Out-Patient
☐ Herpes
☐ Measles RT-PCR
☐ Mumps RT-PCR
☐ Trioplex RT-PCR

☐ QuantiFeron TB-Gold Plus Incubation Start Time: End Time:

☐ COVID RT-PCR	Y	N	U		Y	N	U
First Test?	☐	☐	☐	Hospitalized?	☐	☐	☐
Employed in healthcare?	☐	☐	☐	ICU?	☐	☐	☐
Symptomatic (CDC defined)?	☐	☐	☐	Pregnant?	☐	☐	☐
Resident in a congregate care facility?					☐	☐	☐

Special Pathogens

Rule-out Testing	Molecular Testing for Viral Pathogens		Serological Testing
☐ Bacterial Isolate ☐ Clinical Specimen Suspect Agent:_____	☐ Avian Influenza	☐ Ebola	☐ BMAT
	☐ MERS	☐ Other	☐ Malaria

1335

INSTRUCTIONS FOR COMPLETING REQUEST FORM
1335 -ENG-DPH

(*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 DPH records retention schedule 8581, “Requests for Laboratory Analysis”, Records Group Number: 169.