

1. Last Name	First Name	MI
2. Patient Number (Soc. Security No.)		H
Submitter Laboratory/Medical Record #:		
3. Address	4. Date of Birth	
Zip Code	Month	Day Year
5. Race	<input type="checkbox"/> 1. White <input type="checkbox"/> 2. Black <input type="checkbox"/> 3. American Indian <input type="checkbox"/> 4. Asian <input type="checkbox"/> 5. Native Hawaiian/Pacific Islander <input type="checkbox"/> 6. Unknown	
6. Hispanic or Latino Origin:	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 3. Unknown	
7. Sex	8. Co. of Residence	
9. Medicaid Client	If yes, enter #	

DO NOT WRITE IN THIS SPACE

LABORATORY NUMBER

DATE RECEIVED

North Carolina
 Department of Health and Human Services
State Laboratory of Public Health
 Leslie Wolf, Ph.D., Director
 Microbiology Branch
 306 N. Wilmington St. • P.O. Box 28047
 Raleigh, NC 27611-8047
 Phone: (919) 733-7367
 Fax: (919) 733-8695

PLEASE GIVE ALL INFORMATION REQUESTED

SPECIMEN TYPE: ISOLATED ORGANISM** SMEAR CLINICAL*

*Fill out reverse of form

DATE SPECIMEN COLLECTED	
M	D Y

EXAMINE FOR:

GC N. MENINGITIDIS GROUP H. INFLUENZAE TYPE

BORDETELLA PCR BORDETELLA CULTURE LEGIONELLA DFA

LEGIONELLA CULTURE REFERENCE ID**

**Describe organism _____

SPECIMEN SOURCE:

BLOOD CSF URINE SPUTUM NP BRONCH WASH

BRONCH LAVAGE BRONCH BRUSH THROAT

STERILE BODY FLUID WOUND-SITE _____

GENITAL-SITE _____ OTHER _____

SPECIAL/ATYPICAL BACTERIOLOGY

LABORATORY REPORT (DO NOT WRITE BELOW)

IDENTIFICATION

GRAM STAIN

HIA
 ACTION ON BLOOD
 TSI: SLANT/BUTT

H2S: TSI BUTT
 HS2: LEAD AC
 PAPER
 OXIDASE
 CATALASE

ACETAMIDE
 ACETATE
 AGAR ADHERENCE
 BILE ESCULIN
 BILE SOLUBILITY
 CETRIMIDE
 CITRATE
 COAG.: SLIDE
 TUBE

DMSO OXIDASE
 ESCULIN
 FLAGELLA
 FLO
 GAS/GLU M.R.S.
 GELATIN
 INDOL
 LAP
 LECITHINASE
 LITMUS MILK
 MACCONKEY
 MOTILITY
 MR
 NITRATE
 NITRITE
 ONPG

PA
 PIGMENT
 PYR
 PYRUVATE
 STARCH
 STRING TEST
 SS
 TECH
 UREA
 VP
 3% KOH GEL

DECARBOXYLASES:
 ARGININE
 LYSINE
 ORNITHINE

BASE:
 ARABINOSE
 FRUCTOSE
 GLUCOSE
 INULIN
 LACTOSE
 MALTOSE
 MANNITOL
 MANNOSE
 MELIBIOSE
 RAFFINOSE
 SALICIN
 SORBITOL
 SUCROSE
 TREHALOSE
 TURANOSE
 XYLOSE

DATE REPORTED: _____ **By** _____

REPORT TELEPHONED TO: _____ **By** _____

CULTURE REPORT TO FOLLOW

FINAL CULTURE REPORT _____ **By** _____

SENT TO CDC FOR FURTHER TESTING

CULTURE SHOWS NO BACTERIAL GROWTH NONVIABLE ISOLATE

GROSSLY MIXED CULTURE

DIRECT FA STAIN FOR _____

POSITIVE NEGATIVE (DFA STAIN IS A PRESUMPTIVE TEST)

CULTURE FOR BORDETELLA POSITIVE NEGATIVE

CULTURE FOR LEGIONELLA POSITIVE NEGATIVE

PCR FOR BORDETELLA POSITIVE NEGATIVE

SPECIMEN UNSATISFACTORY: _____

BROKEN/LEAKED IN TRANSIT SPECIMEN UNLABELED

QUANTITY INSUFFICIENT SPECIMEN IMPROPERLY PREPARED

NO SPECIMEN FORM IMPROPERLY PREPARED

%NACL: 0% 6% 6.5% 8% 10%
 GROWTH TEMP.: 10C 25C 35C 42C 45C

SEROLOGICAL GROUP GROWTH ON MEDIA: ANTIBIOTIC DISCS:

CA SBA MAC GCLT RAB

DNA PROBE MAC

DNASE GCLT

AMYLOSUCRASE RAB

NUT. AGAR 35C/AIR

GONOCHEK

GONOGEN

VANCOMYCIN
 POLYMYXIN B
 NOVOBIOCIN
 FURAZOLIDONE
 OPTOCHIN
 COLISTIN
 PENICILLIN

Comments:

PLEASE PROVIDE THE FOLLOWING CLINICAL OR EPIDEMIOLOGIC INFORMATION

ANY ASSOCIATED ILLNESS _____ DATE OF ONSET _____

PERTINENT CLINICAL FINDINGS _____ SYMPTOMS _____

PREVIOUS LABORATORY RESULTS _____

EPIDEMIOLOGICAL DATA: SINGLE CASE SPORADIC CONTACT EPIDEMIC CARRIER ANIMAL CONTACT _____

FOREIGN OR DOMESTIC TRAVEL? WHERE? _____ WHEN? (WITHIN LAST YEAR) _____

OTHER _____

INSTRUCTIONS

PURPOSE: Isolation, identification, confirmation, further studies of human disease-producing mycobacteria.

PREPARATION: Collect specimen following instructions in SCOPE, using recommended collection kits. Label each specimen tube, subculture, or smear with patient's name and your laboratory number if appropriate. Fill out this form and send in appropriate mailer with the specimen to State Laboratory of Public Health. Place form in **outer** container. Do not send without label (patient name) on specimen or without form. Forms must be printed from Web site.

PREPARATION OF FORM: *Left Upper Portion of Form.* Item 1. Enter patient's name, last name first, first name, and middle initial or maiden name initial, if female. Item 2. Enter patient's social security number. **This is the identifying number for that patient.** If the patient has no social security number, please indicate on form and include submitter laboratory/medical record number. Item 3. Enter patient's **home** address on lines immediately below. This information is required for epidemiologic follow-up. Item 4. Enter date of birth (not age). Items 5, 6, and 7. Indicate race, Hispanic Ethnicity, and sex by checking appropriate box. These data are for statistical purposes only. Item 8. Enter county of residence of patient (Health Departments use county code). Item 9. Indicate if patient is a Medicaid client; if yes, enter Medicaid number. Item 10. Indicate if patient is a Family Planning or EPSDT client by checking box. Enter submitter federal tax number or social security number in blank. **ALSO ENTER RETURN ADDRESS OF SUBMITTER** in box under "Send Report To:".

Right Upper Portion of Form. Specimen Type: Check appropriate box. Date Specimen Collected: Enter date as indicated. Examine For: Suspected disease or type examination required. Specimen Source: Check appropriate box. Symptoms/Epidemiological Information: Check appropriate box(es). Provide any further information listed at top of this page.

Do not write in space below "Laboratory Report."

DISPOSITION: This form may be destroyed in accordance with Standard 5, Patient Clinical Records, of the *Records Disposition Schedule* published by the N.C. Division of Archives and History.