

ENTERIC BACTERIOLOGY (ENTEROBACTERIALES)

N.C. Department of Health and Human Services
 State Laboratory of Public Health
 4312 District Drive • P.O. Box 28047
 Raleigh, NC 27611-8047

Lab Use Only	<input type="checkbox"/> Acceptance Criteria Not Met
	<input type="checkbox"/> Inappropriate temperature
	<input type="checkbox"/> Specimen too old
	<input type="checkbox"/> Incomplete labeling/form
	<input type="checkbox"/> Specimen inappropriate/damaged
Date: ___/___/___ Initials: _____	

Please Give All Information Requested

Attach Printed Label Below

Patient Information	Last Name				
	First Name	MI			
	Maiden Name/Surname				
	Address/Attention:				
	Street Address:		Address 2:	City:	
	State:	Zip Code:	County Code:	County Name:	Phone Number:
	SSN: _____		Medicaid Number (if applicable): _____		
Medical Record Number:		Date of Birth: ___/___/___			
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Transgender M2F <input type="checkbox"/> Female <input type="checkbox"/> Transgender F2M <input type="checkbox"/> Unknown <input type="checkbox"/> Transgender Unknown <input type="checkbox"/> Ambiguous		Race (mark all that apply): <input type="checkbox"/> White <input type="checkbox"/> American Indian/ <input type="checkbox"/> Black Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/ <input type="checkbox"/> Unknown Pacific Isles		Ethnicity: <input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	
Submitter	EIN: _____		Submitter (Facility) Name:		
	Address:		Address 2:	City:	
	State:		Zip Code:	County Name:	
	Phone Number:		Email Address:	Fax Number:	
	Ordering Provider NPI:		Ordering Provider First and Last Name:		
Specimen	Collection Date: ___/___/___ Collection Time: 24 Hr _____:____ Time		Reason for Testing (ICD-10 Dx Code): _____		
	Specimen Type: <input type="checkbox"/> Reference isolate <input type="checkbox"/> Clinical (primary patient specimen for culture) CIDT (culture-independent diagnostic test) <input type="checkbox"/> Yes <input type="checkbox"/> No		Specimen Source: <input type="checkbox"/> Stool <input type="checkbox"/> Rectal Swab <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Wound Site: _____ <input type="checkbox"/> Other: _____		
	CIDT additional information: Please attach copy of CIDT report and identify method used below: <input type="checkbox"/> BioFire® <input type="checkbox"/> BD MAX® <input type="checkbox"/> Luminex xTAG® <input type="checkbox"/> LDT (lab developed test) <input type="checkbox"/> Verigene® <input type="checkbox"/> Other _____		Microbiology Test request/ Pathogen(s) identified: <input type="checkbox"/> Enteric pathogens (includes all below) <input type="checkbox"/> Aeromonas only <input type="checkbox"/> Campylobacter only <input type="checkbox"/> E. coli 0157/ STEC only <input type="checkbox"/> Salmonella only <input type="checkbox"/> Shigella only <input type="checkbox"/> Yersinia only <input type="checkbox"/> Vibrio only		
			Unusual reference isolate identification <input type="checkbox"/> Glucose fermenting Gram-negative rod		
Epi	Molecular Test request/ Pathogen(s) identified: <input type="checkbox"/> CRE (surveillance) <input type="checkbox"/> Norovirus (outbreak-associated)				
	Please complete if applicable: Foreign or domestic travel? Where? _____ Suspect foodborne? Food handler? _____ Daycare? _____				