11

Lab Use Only

☐ **Acceptance Criteria Not Met**
☐ Inappropriate temperature
☐ Specimen too old
☐ Incomplete labeling/form
☐ Specimen inappropriate/damaged

Date: ____ __ /___/____
Initials:_____

ENTERIC BACTERIOLOGY (ENTEROBACTERALES)

N.C. Department of Health and Human Services
State Laboratory of Public Health
4312 District Drive
Raleigh, NC 27607

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:
Insurance ID Number: (if applicable)			Medicaid Number (if applicable): __ __ __ __ __ __ __ __ __ __	
Medical Record Number:			Date of Birth: ____ / ____ / _____	
Sex: ❑ Male ❑ Transgender M2F ❑ Female ❑ Transgender F2M ❑ Unknown ❑ Transgender Unknown ❑ Ambiguous			Race (mark all that apply): ❑ White ❑ American Indian/ ❑ Black Alaska Native ❑ Asian ❑ Native Hawaiian/ ❑ Unknown Pacific Isles	Ethnicity: ❑ Hispanic or Latino Origin ❑ Non-Hispanic ❑ 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: ❑ Reference isolate ❑ Clinical (primary patient specimen for culture) ❑ CIDT (culture-independent diagnostic test)	**Specimen Source:** ❑ Stool ❑ Rectal Swab ❑ Blood ❑ Urine ❑ Wound Site: _ _____ ❑ Other: _____

	CIDT additional information: Please attach copy of CIDT report and identify method used below: ❑ BioFire® ❑ BD MAX® ❑ Luminex xTAG® ❑ LDT (lab developed test) ❑ Verigene® ❑ QIASTAT ❑ Cepheid Xpert ❑ Other_____	**Microbiology Test request/ Pathogen(s) identified:** ❑ Enteric pathogens (includes all below) ❑ Aeromonas only ❑ Campylobacter only ❑ Shiga like toxin E.coli (STEC) / O157 only ❑ Salmonella only ❑ Shigella only ❑ Yersinia only ❑ Vibrio only **Unusual reference isolate identification:** ❑ Glucose fermenting Gram-negative rod **ARLN Test Request:** ❑ ARLN Panel ❑Organism Id (genus species) _____ ❑ Mechanism of resistance_____ **Molecular Test request/ Pathogen(s) identified:** ❑ Norovirus (outbreak-associated)
Epi	**Please complete if applicable:** Foreign or domestic travel? Where? _____ Suspect foodborne outbreak? _____ Daycare? Food handler? Healthcare worker?_____	