ENTERIC BACTERIOLOGY (ENTEROBACTERALES)

Lab Use Only

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

Date: ___/___/_____ Initials:_____

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 ◯ Female ◯ Unknown ◯ Ambiguous ◯ Transgender M2F ◯ Transgender F2M ◯ Transgender Unknown			Race (mark all that apply): ☐ White ☐ Black ☐ Asian ☐ Unknown ☐ American Indian/ Alaska Native ☐ Native Hawaiian/ 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) ☐Yes ☐No	**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® ☐ Other_____	**Microbiology Test request/ Pathogen(s) identified:** ☐ Enteric pathogens (includes all below) ☐ Aeromonas only ☐ Campylobacter only ☐ E. coli 0157/ STEC only ☐ Salmonella only ☐ Shigella only ☐ Yersinia only ☐ Vibrio only **Unusual reference isolate identification:** ☐ Glucose fermenting Gram-negative rod **ARLN Test Request:** ☐ ARLN Panel **Molecular Test request/ Pathogen(s) identified:** ☐ Norovirus (outbreak-associated)

Epi

Please complete if applicable:
Foreign or domestic travel? Where? _____
Suspect foodborne? Food handler? _____
Daycare?_____