Dartmouth-Hitchcock

Department of Pathology and Laboratory Medicine
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Required Fields*

Microbiology (Virology/Special Micro)

***Patient Full Legal Name (First and Last):**

***DH MRN:**

*Referring Identifier:

Copy To:

***Date of Birth:** / /

***Collection Date and Time:**

*Ordering Provider (print):

*Billing Provider (print):

***SEX**: Female ☐ Male ☐

Patient Type: ☐ Inpatient ☐ Outpatient

Location:

Skilled Nursing Facility: Yes ☐ No ☐

***PATIENT ID CONFIRMED & SPECIMEN COLLECTED BY - SIGNATURE:**

*DIAGNOSIS/Reason for Testing (REQUIRED) / ICD-10:

***BOTH SOURCE AND TEST MUST BE SELECTED**

BLOOD

Source	TEST
☐ Peripheral Blood	☐ Bartonella PCR (EDTA)(M)
	☐ Cryptococcal Antigen (10 ml SST)
	☐ EBV Quantitative PCR (EDTA) (M)
M= mailout test	☐ Herpesvirus 6 (HHV-6) PCR (EDTA)(M)
	☐ Lyme Antibody (SST)
	☐ Other (specify)_____

URINE

Source	TEST
☐ Urine	☐ Chlamydia Gene amplification
	☐ GC Gene Amplification
	☐ Trichomonas Gene Amplification
	☐ Legionella Urinary Antigen
	☐ CMV culture

FLUID/WOUND/TISSUE

Source	TEST
☐ CSF	☐ CMV Qualitative PCR (CSF only)(M)
☐ Fluid	☐ CMV Culture
Specify_____	☐ Cryptococcal AG (CSF only)
☐ Tissue	☐ EBV PCR Qualitative (CSF only)(M)
Specify_____	☐ Enterovirus PCR (CSF only)
	☐ HSV PCR (CSF only)
	☐ Herpesvirus 6 (HHV-6) PCR-CSF only (M)
M= mailout test	☐ Mycobacteria Tuberculosis complex TB PCR (M)
	☐ Mycoplasma pneumoniae PCR (CSF only)(M)
	☐ Toxoplasma gondii PCR (CSF only)
	☐ Parvovirus B19 PCR (CSF only) (M)
	☐ Varicella -Zoster PCR (CSF only)(M)
	☐ Virus Culture_____(specify)

RESPIRATORY

Source	TEST
☐ Nasopharyngeal swab* *must be send in viral transport media	☐ Influenza A, B & RSV (PCR)
	☐ Full resp. viral panel (16 targets)(Aptima)
☐ Throat *	☐ Chlamydia Gene amplification (Aptima)
	☐ GC Gene Amplification (Aptima)

GENITAL

Source	TEST
☐ Cervix	☐ GC Gene Amplification
☐ Urethra	☐ Chlamydia Gene amplification
☐ Vaginal	☐ Trichomonas Gene Amplification

*Send specimens in Aptima transport tube

☐ Lesion/Vesicle	
☐ Other:_____	☐ HSV PCR*

*must be sent in viral transport media

Lesion Vesicle

H-2570 3/2018

☐ Lesion/Vesicle	☐ HSV PCR
Site_____	
	☐ VZV DFA Rapid Stain (must be sent on a slide)
*culture and PCR must be submitted in viral transport media	☐ *reflex to culture if stain negative
	☐ *VZV Culture

*Send specimens in Aptima transport tube
**Send specimen in viral transport media

EYE

Source	TEST
☐ Conjunctiva	☐ *GC Gene Amplification
☐ Corneal Scraping	☐ *Chlamydia Gene Amplification
☐ Vitreous Fluid	☐ **Adenovirus culture
☐ Other:_____	☐ **Enterovirus culture
	☐ **HSV Culture/HSV PCR(conjunctiva site)
	☐ **VZV Culture

REFER TO LABORATORY HANDBOOK FOR ADDITIONAL INFROMATION: https://one-dh.testcatalog.org/

SEND ALL SPECIMENS TO LABORATORY VIA COURIER OR TUBE STATION