


**Alabama Department of Public Health (ADPH)  
Infectious Diseases & Outbreaks Division (ID&O) Partner Instructions**

ADPH contacted your facility because you are providing care to a patient either involved in a notifiable disease outbreak; has influenza-like illness and international travel; or has tested positive for invasive pneumococcal disease and is < 5 years of age, meningococcal disease, or *Haemophilus influenzae*. ID&O is requesting the patient's specimen(s) be sent for testing to the Bureau of Clinical Laboratories (BCL) in Montgomery through your county health department. Please go to [www.adph.org/bcl](http://www.adph.org/bcl), print the Requisition Form, complete the minimum red highlighted fields, and enter the outbreak ID # if applicable.

Bureau of Clinical Laboratories P.O. Box 244018 Montgomery, AL 36124-4018 334-260-3400		Alabama Department of Public Health (ADPH) Bureau of Clinical Laboratories (BCL) <b>Requisition Form for Laboratory Testing</b>		Mobile Division Laboratory 757 Museum Drive Mobile, AL 36608 251-344-6049		
As of 1/1/14, all specimens (except newborn screening) require the patient's demographic and insurance information. Complete a separate form for each test requested.						
<b>Patient Information</b> Patient ID Number/MRN _____ Specimen Collection Date _____ Patient Name (Last and First) _____ Date of Birth (mm/dd/yyyy) _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____ Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Unknown _____ Patient SSN _____ Patient Street Address _____ City _____ State _____ Zip _____ Phone Number _____		<b>Health Care Provider Information</b> Facility Name _____ Physician/Requestor Name (Last and First) _____ NPI# _____ Street Address _____ City _____ State _____ Zip _____ Phone Number _____ Fax Number _____ Laboratory Use Only _____				
<b>Insurance Information (Please include copy of insurance card)</b> Bill To: <input type="checkbox"/> Patient's Insurance <input type="checkbox"/> Patient <input type="checkbox"/> Ordering Facility <input type="checkbox"/> ADPH Program Insurance Carrier: <input type="checkbox"/> BC/BS <input type="checkbox"/> United Healthcare <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> No Insurance <input type="checkbox"/> Other (Specify) _____ Policy Holder's Name (Last, First, MI) _____ ID Number _____ Group Number _____ Policy Holder's DOB (mm/dd/yyyy) _____ Policy Holder's Mailing Address _____ Patient's Relationship to Policy Holder (Self, Child, Spouse, Unknown) _____ Insurance Phone No. _____ Insurance Mailing Address _____ Coverage Effective Date _____						
Diagnosis Code(s): Code 1 _____ Code 2 _____ Code 3 _____						
<b>Test Requested</b> Specimen Type: _____ <table border="0"> <tr> <td> <b>Frequency Orders</b>  <input type="checkbox"/> CT/GC/TV  <input type="checkbox"/> Syphilis  <input type="checkbox"/> HIV ELA HIV ELA Form  <input type="checkbox"/> Blood Lead <input type="checkbox"/> Capillary <input type="checkbox"/> Venous Follow-up? Yes/No  <input type="checkbox"/> HIV Genotyping <input type="checkbox"/> HIV Load  <input type="checkbox"/> Lymphocyte Subset (CD4)  <input type="checkbox"/> Hepatitis B Surface Antibody <input type="checkbox"/> Hepatitis B Surface Antigen  <input type="checkbox"/> Post Vaccine Response? Yes/No <input type="checkbox"/> Pre-vaccine? Yes/No  <input type="checkbox"/> CBC without differential                      Chemistry Panel (Only one form required per Chemistry Request)  <input type="checkbox"/> Comprehensive Metabolic <input type="checkbox"/> Lipid  <input type="checkbox"/> Basic Metabolic <input type="checkbox"/> Thyroid  <input type="checkbox"/> Renal Function <input type="checkbox"/> TB  <input type="checkbox"/> Hepatic Function <input type="checkbox"/> Electrolytes  <input type="checkbox"/> Chemistry Analyte (s) _____  <input type="checkbox"/> Influenza Rapid test result: _____ Date of onset: _____  <input type="checkbox"/> Urine Culture  <input type="checkbox"/> Arboviral Testing Agent suspected: _____  <input type="checkbox"/> WNV Date of onset: _____  <input type="checkbox"/> EEE  <input type="checkbox"/> SLE  <input type="checkbox"/> Lactose <b>Select lab test</b>  <input type="checkbox"/> Other Test _____                 </td> <td> <b>AFB/Mycology/Microbiology</b>  <input type="checkbox"/> AFB  <input type="checkbox"/> Mycology  <input type="checkbox"/> Microbiolo - Reference Gram Stain _____  <input type="checkbox"/> Microbiolo - Salmonella/Shigella _____  <input type="checkbox"/> Microbiolo - PCR Test _____  <input type="checkbox"/> Other _____                      Agent suspected: _____                      Special Instructions: <u>Enter outbreak ID # given by</u>  <u>ADPH lead Area Investigator</u>  <u>List suspected organism</u>                      _____                      _____                      _____                 </td> </tr> </table>					<b>Frequency Orders</b> <input type="checkbox"/> CT/GC/TV <input type="checkbox"/> Syphilis <input type="checkbox"/> HIV ELA HIV ELA Form <input type="checkbox"/> Blood Lead <input type="checkbox"/> Capillary <input type="checkbox"/> Venous Follow-up? Yes/No <input type="checkbox"/> HIV Genotyping <input type="checkbox"/> HIV Load <input type="checkbox"/> Lymphocyte Subset (CD4) <input type="checkbox"/> Hepatitis B Surface Antibody <input type="checkbox"/> Hepatitis B Surface Antigen <input type="checkbox"/> Post Vaccine Response? Yes/No <input type="checkbox"/> Pre-vaccine? Yes/No <input type="checkbox"/> CBC without differential Chemistry Panel (Only one form required per Chemistry Request) <input type="checkbox"/> Comprehensive Metabolic <input type="checkbox"/> Lipid <input type="checkbox"/> Basic Metabolic <input type="checkbox"/> Thyroid <input type="checkbox"/> Renal Function <input type="checkbox"/> TB <input type="checkbox"/> Hepatic Function <input type="checkbox"/> Electrolytes <input type="checkbox"/> Chemistry Analyte (s) _____ <input type="checkbox"/> Influenza Rapid test result: _____ Date of onset: _____ <input type="checkbox"/> Urine Culture <input type="checkbox"/> Arboviral Testing Agent suspected: _____ <input type="checkbox"/> WNV Date of onset: _____ <input type="checkbox"/> EEE <input type="checkbox"/> SLE <input type="checkbox"/> Lactose <b>Select lab test</b> <input type="checkbox"/> Other Test _____	<b>AFB/Mycology/Microbiology</b> <input type="checkbox"/> AFB <input type="checkbox"/> Mycology <input type="checkbox"/> Microbiolo - Reference Gram Stain _____ <input type="checkbox"/> Microbiolo - Salmonella/Shigella _____ <input type="checkbox"/> Microbiolo - PCR Test _____ <input type="checkbox"/> Other _____ Agent suspected: _____ Special Instructions: <u>Enter outbreak ID # given by</u> <u>ADPH lead Area Investigator</u> <u>List suspected organism</u> _____ _____ _____
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