MONTANA DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Public Health Laboratory Request Form

P.O. Box 4369, Helena, MT 59604-4369
(406) 444-3444 (800) 821-7284 CLIA ID # 27D0652531

DPHHS PHL 0117

PATIENT INFORMATION (please PRINT legibly)

LAST NAME

FIRST NAME

SUBMITTER PATIENT ID/ MEDICAL RECORD NUMBER

PATIENT ZIP CODE

DATE OF BIRTH ___ / ___ / ___

GENDER: ☐ Male ☐ Female ☐ Trans M>F ☐ Trans F>M ☐ Undisclosed

Medicaid / Medicare Billing Information:

☐ Bill MEDICAID ☐ Inpatient
☐ Bill MEDICARE ☐ Outpatient

MEDICAID or MEDICARE NUMBER

ICD Diagnosis Codes:

FACILITY/PROVIDER INFORMATION

FACILITY ACCOUNT #/ADDRESS

LS160011
BOZEMAN HEALTH
915 HIGHLAND BLVD
BOZEMAN, MT 59715

PHYSICIAN: LAST NAME, FIRST NAME

NATIONAL PROVIDER IDENTIFIER (NPI)

MTPHL USE ONLY

TEST(S) REQUESTED INFORMATION

Serology:

- ☐ Blood Lead
- ☐ Brucella Antibody
- ☐ Colorado Tick Fever IgG
- ☐ Fungal Serology
- ☐ Hantavirus IgM Serology
- ☐ Hepatitis - Acute Panel
- ☐ Hepatitis A IgM Antibody
- ☐ Hepatitis B Surface Antigen
- ☐ Hepatitis B Surface Antibody
- ☐ Hepatitis B Total Core Antibody
- ☐ Hepatitis B Core IgM Antibody
- ☐ Hepatitis C Ab with Reflex Confirmation
- ☐ Herpes Simplex Virus IgG Serology
- ☐ HIV Ab/Ag Combo with Reflex Confirmation
- ☐ HIV Confirmation (Geenius)
- ☐ Lyme Total Abs with Reflex Confirmation
- ☐ Measles (Rubeola) IgG
- ☐ Mumps IgG Serology
- ☐ Q Fever IgG Serology
- ☐ Rocky Mtn Spotted Fever IgG
- ☐ Rubella IgG
- ☐ Syphilis Screen with Reflex Confirmation
- ☐ Syphilis Titer Only
- ☐ TB - QuantiFERON Gold In-Tube Testing
  Time Collected: _____
  Incubated 16 - 24 hrs? Yes No
- ☐ Tick Borne Disease Panel + Lyme
- ☐ Tularemia Antibody
- ☐ Varicella Zoster Virus IgG
- ☐ West Nile Virus IgG
- ☐ West Nile Virus IgM
- ☐ Other Serology (indicate in comments)

Molecular:

- ☐ Adenovirus PCR
- ☐ Bordetella pertussis multitarget PCR
- ☐ C difficile/NAP1 PCR
- ☐ Chlamydia (Aptima)
- ☐ Chlamydia/Gonorrhea (Aptima)
- ☐ Enterovirus PCR
- ☐ Enterovirus D68 PCR
- ☐ Gonorrhea (Aptima)
- ☐ Hepatitis C RNA Quantitation
- ☐ Herpes Simplex I/II (Aptima)
- ☐ HIV RNA Quantitation (Plasma only)
- ☐ Influenza A and B PCR
- ☐ Influenza Surveillance
- ☐ Measles (Rubeola) PCR
- ☐ Mumps PCR
- ☐ Norovirus PCR
- ☐ Varicella Zoster PCR

Sterilizer Monitoring:

- ☐ Autoclave Monitoring - Q/C Test

Micro Surveillance:

Organism: _____

- ☐ Carbapenem Resistant Enterobacteriaceae
- ☐ Carbapenem Resistant Pseudomonas
- ☐ Neisseria gonorrhoeae Confirmation
- ☐ Neisseria meningitis Confirmation
- ☐ Haemophilus influenzae Confirmation
- ☐ Salmonella/Shigella/E. coli/Campy
- ☐ Vibrio Confirmation
- ☐ Yersinia Confirmation
- ☐ Other Confirmation (indicate in comments)

TB/Mycobacteriology:

- ☐ TB Mycobacteria Smear/Culture/ID
- ☐ M. tuberculosis NAAT (Molecular)
  (Should be ordered on all highly suspect specimens)

Zika Testing (Is the patient pregnant? Y / N)

- ☐ Zika Trioplex PCR Serum
- ☐ Zika Trioplex PCR Serum/Urine Combo
  (Trioplex PCR Includes Dengue and Chikungunya)

Reference Microbiology:

- ☐ Bacteriology Culture/ID, Aerobic
- ☐ Bacteriology Culture/ID, Anaerobic
- ☐ BT Agent Rule Out (list in Comments)
- ☐ E. Coli O157:H7 Screen
- ☐ EHEC (STEC) Toxin Test
- ☐ Enteric Panel Culture, includes EHEC
- ☐ ESBL Confirmation
- ☐ Legionella Direct Detection/Culture/ID
- ☐ MRSA Confirmation
- ☐ Neisseria gonorrhoeae Culture/ID
- ☐ Salmonella/Shigella Test of Cure
- ☐ Vibrio screen
- ☐ VRE Confirmation
- ☐ Yersinia screen

Mycology/Parasitology:

- ☐ Fungal Culture/ID
- ☐ Modified Acid Fast Stain
- ☐ Cryptosporidium/Cyclospora Detection
- ☐ Malaria/Blood Parasite Screen
  - call before sending
- ☐ Ova and Parasite Exam
- ☐ Yeast ARLN Study

SPECIMEN DETAILS

SUBMITTER SPECIMEN ID/ACCESSION #

SPECIMEN COLLECTION DATE ___ / ___ / ___

DATE OF ONSET (if applicable) ___ / ___ / ___

Please call 1-800-821-7284 for more forms

DO NOT PHOTOCOPY

- ☐ Autoclave QC Vial
- ☐ Biopsy (specify below)
- ☐ Blood-Heparinzed
- ☐ Blood-EDTA (Capillary)
- ☐ Blood-EDTA (Venous)
- ☐ Blood (for culture)
- ☐ Bronchial Alveolar Lavage
- ☐ Bronchial Washings
- ☐ CSF
- ☐ Fluid-Pleural
- ☐ Fluid (specify below)
- ☐ Nasal Washings
- ☐ Plasma
- ☐ Serum
- ☐ Sputum
- ☐ Stimulated Plasma (QFT)
- ☐ Stool
- ☐ Swab-Buccal
- ☐ Swab-Endocervical
- ☐ Swab-Lesion (specify below)
- ☐ Swab-Nasal
- ☐ Swab-Nasopharyngeal
- ☐ Swab-Rectal
- ☐ Swab-Throat
- ☐ Swab-Urethral
- ☐ Swab-Vaginal
- ☐ Tissue-Lung
- ☐ Tissue (specify below)
- ☐ Urine
- ☐ Other _____

Additional specimen details/source site

Other Test(s) Requested/ Pertinent Information / Comments

- ☐ COVID-19

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