GEORGIA PUBLIC HEALTH LABORATORY SUBMISSION FORM

Georgia Department of Public Health

(Not to be used for Newborn Screening Tests)

Complete a separate form for each test requested

Effective 7/1/2013

Please Do Not Submit this form prior to 7/1/2013

Laboratory use only

Choose Lab to Perform Test

☐ Decatur ☐ Waycross

HEALTH CARE PROVIDER INFORMATION

Submitter Code

Submitter Name

Street Address

City | **State** | **Zip**

Phone Number

Fax Number

Contact Name

PATIENT INFORMATION

Patient ID Number | **PATIENT NAME (Last)** | **First** | **MI** | **Suffix**

County of Residence | **DOB** ___/___/_____

Home Phone: | **Work Phone:** | **Cell Phone:**

Address | **City,** | **State** | **Zip**

Parent / Guardian (if applicable) | **Relationship**

RACE

☐ American Indian/Alaska Native ☐ Asian
☐ Black/African-American
☐ Native Hawaiian/Pacific Islander
☐ White/ Caucasian
☐ Multi Racial

ETHNICITY

☐ Hispanic or Latino
☐ Non-Hispanic or Latino

Sex

☐ Male
☐ Female

Pregnant?

☐Yes ☐No ☐N/A

☐ **SELF PAY** (SUBMITTER WILL BE INVOICED) ☐**APPROVAL CODE:** _____-_____-_____-_____ *(Submitter will be billed if a valid code is not provided)*

INSURANCE INFORMATION – COPY OF PATIENT'S INSURANCE ELIGIBILITY DOCUMENT MUST BE SUBMITTED WITH THIS FORM

ACCEPTED INSURANCE

☐ Amerigroup
☐ Peach State
☐ Wellcare
☐ Medicaid/ Peachcare

ID Number | **Plan Name** | **Group Number** | **Policy Holder's Name (Last, First, M)**

Policy Holder's DOB | **Policy Holder's Mailing Address** | **Patient's Relationship to Policy Holder**

___/___/_____

FOR FUTURE USE

Insurance Phone # | **Insurance Mailing Address** | **Coverage Effective Date**

___/___/_____

ICD 9 Diagnosis Codes
Required for insurance purposes only.

Sequence Code 1 | Sequence Code 2 | Sequence Code 3

SPECIMEN INFORMATION

All tests are performed at the Decatur Laboratory unless specified.

☐ Arthropod
☐ Abscess
☐ Blood
☐ Body fluid
☐ Bronchial Wash
☐ CSF
☐ Endocervical
☐ Isolated Organism
☐ Lesion/General Swab
☐ Lesion/Genital Swab
☐ Nasopharyngeal Aspirate
☐ Nasopharyngeal Swab
☐ Pinworm
☐ Plasma
☐ Rectal Swab
☐ Serum (Acute/Convalescent)
☐ Sputum
☐ Stool/Feces
☐ Throat/Pharynx
☐ Tissue
☐ Urethra
☐ Urine
☐ Other _____

Date of Collection
___/___/_____

Time of Collection
___:___ ☐AM ☐PM

SHIPPED
☐ Frozen
☐ Refrigerated
☐ Room Temperature

Outbreak related ☐ Yes ☐ No
If yes, name of outbreak:
_____

Travel ☐ Yes ☐ No
Where?
_____

Symptoms
_____
_____
_____

TEST REQUESTED

BLOOD LEAD
(Waycross Only)

☐ **W4050 Waycross**

COLLECTION METHOD
☐ Capillary ☐ Venus

MOLECULAR BIOLOGY
(Decatur only)
Consultation with district epidemiologist required.

☐ **BT agent rule out (RT-PCR)**
- ☐ BTC01005 *Bacillus anthracis*
- ☐ BTC02005 *Brucella spp.*
- ☐ BTC03005 *B. mallei/pseudomallei*
- ☐ BTC04005 *Francisella tularencis*
- ☐ BTC06005 *Yersinia pestis*
- ☐ BT99000 BT send out CDC

☐ 414000 **Bordetella pertussis (RT-PCR)**
☐ 400050 **Influenza panel (rRT-PCR)**
☐ 413000 **Mumps (RT-PCR)**
☐ 416000 **Measles (RT-PCR)**
☐ 1305 **Norovirus (rRT-PCR)**
☐ BTC05000 **Rash Illness Panel (RT-PCR)**
☐ 421000 **VZV (RT-PCR)**
☐ 499100 **Refer to CDC**

_____

CHEMICAL THREAT
(Decatur only)
Consultation with GPHL Emergency Response Coordinator required.
24/7 contact number 404-655-3695
866-782-4584

☐ CT041100 Rapid Toxic Screen (RTS) (Performed at the CDC)
☐ CT021500 Cadmium, mercury and lead (blood)
☐ CT021700 Toxic Elements Screen (TES) (urine) (As, Ba, Be, Cd, Pb, Tl, U)
☐ CT021600 Mercury (urine)
☐ CT011100 Cyanide (blood)
☐ CT011200 Volatile Organic Compounds (VOC) (blood)
☐ CT011300 Tetramine (urine)
☐ CT031100 Organophosphate Nerve Agent metabolites (OPNA) (urine)
☐ CT031200 Metabolic Toxins Panel (MTP) (urine)
☐ CT031300 Abrine and Ricinine (ABRC) (urine)
☐ Hold for testing

Illness related to chemical exposure
☐ Yes ☐ No
Name/ID number of event _____

A correlating list of tests and prices is located at http://health.state.ga.us

PATIENT NAME
Last: First: MI.

For Laboratory Use Only

BACTERIOLOGY

☐ **Enteric isolates**
- ☐ 1100 Campylobacter
- ☐ 1070 STEC
- ☐ 1110 Salmonella
- ☐ 1080 Shigella
- ☐ 1160 Yersinia

☐ 1120 **Stool Culture - Preserved** (Para-Pak C&S, Room Temp)
- ☐ Routine (Salmonella, Shigella, Campylobacter, Aeromonas, STEC, and Yersinia)
- ☐ *S. aureus* [1]

☐ 1140 **Stool Culture- Fresh** (Refrigerated)
- ☐ *B. cereus* [1]
- ☐ *C. perfringens* [1]

☐ 1130 **Special Bacteriology**
- ☐ *Neisseria meningitidis*
- ☐ *Haemophilus influenzae*
- ☐ *Listeria monocytogenes*
- ☐ *Vibrio sp.*
- ☐ Other- Suspected agent _____

☐ 1040 **Pertussis Direct Fluorescent Antibody (DFA)**
☐ 1050 **Pertussis Culture**
☐ 1030 **Group A Streptococcus**
☐ 1010 **Gonorrhea Culture**
☐ **Nucleic Acid Amplification Test (Chlamydia/Gonorrhea)**
- ☐ **1060 Decatur** ☐ **W1000 Waycross**

☐ 1135 **Forward to CDC[1] (Please specify)** _____
- ☐ *C. botulinum* [1,2]

_____

[1] **Special arrangement required CALL 404-327-7997**
[2] **Epidemiology approval required CALL 404-657-2588**

☐ 1180 **ENVIRONMENTAL / FOOD (Epidemiology Use Only)**
- ☐ B. cereus
- ☐ Campylobacter
- ☐ C. perfringens
- ☐ Listeria
- ☐ STEC / SLT
- ☐ Salmonella
- ☐ Shigella
- ☐ S. aureus

IMMUNOLOGY

Routine Syphilis
☐ Routine RPR *(Choose nearest location)*
- ☐ 1610 Decatur ☐ W2000 Waycross

☐ 1630 VDRL (spinal fluid)
☐ 1640 TPPA

Special RPR testing request
☐ 1615 Quantitative (Titer) and Confirmatory even if screening test (RPR) is negative
☐ No Confirmatory Test needed even if screening test (RPR) is positive

Arbovirus/WNV panel
☐ 1595 Arbo IgG panel
☐ 1600 Arbo IgM panel
☐ 1580 WNV IgG
☐ 1585 WNV IgM
☐ 1590 WNV IgM (CSF)

Hepatitis Testing
☐ 1411 Hep B (Prenatal)
☐ 1410 Hep B (Routine Screen)
☐ 1400 Anti-HAV Total Antibody
☐ 1405 Anti-HAV-IgM
☐ 1480 Anti-HCV
☐ 1490 HCV Viral Load

Miscellaneous Serology
☐ 1530 Toxoplasmosis IgG
☐ 1535 Toxoplasmosis IgM
☐ 1510 Rubella IgG
☐ 1515 Rubella IgM
☐ 1545 CMV IgG
☐ 1550 CMV IgM
☐ 1560 HSV1
☐ 1565 HSV2
☐ 1520 Rubeola IgG
☐ 1525 Rubeola IgM
☐ 1555 Mumps
☐ 1540 Varicella Zoster
☐ 14001 Torch Panel (CMV, HSV1, HSV2, Rubella, and Toxoplasmosis)

☐ 1570 Forward to **CDC** _____

MYCOBACTERIOLOGY

Known TB Patient? ☐ Yes, current ☐ Yes, former ☐ No
Clinical Specimens
- ☐ 30100 Microscopic exam for AFB only
- ☐ 30000 Smear, culture & susceptibility testing (Susceptibility Performed on MTB only)
- ☐ 30800 Nucleic Acid Amplification Testing (NAAT). This test is intended for use only with specimens from newly infected patients showing signs and symptoms of active pulmonary tuberculosis.

AFB Isolates
- ☐ 34000 Identification
- ☐ 33950 Susceptibility testing (MTB only)
- ☐ 30750 Genotyping only

PARASITOLOGY

(Choose nearest location)

Cryptosporidium	☐ 2400 Decatur	☐ W5010 Waycross
Cyclospora	☐ 2500 Decatur	☐ W5010 Waycross
Formalin Feces	☐ 2100 Decatur	☐ W5000 Waycross
PVA Feces	☐ 2300 Decatur	☐ W5020 Waycross
Pinworm slide	☐ 2200 Decatur	☐ W5030 Waycross

☐ 2150 PCR
☐ 2710 Tissue/tissue smear for parasites
☐ 2700 Whole blood/blood smear for parasites - Malaria
☐ 2710 Whole blood/blood smear for parasites - Filaria
☐ 2800 Worm identification
☐ 2800 Miscellaneous identification _____

VIROLOGY

HIV
CTS#_____

☐ 13500 HIV Ag/Ab Combo
☐ 1360 HIV-1 Ab WB
☐ 1340 HIV-1 Viral Load

VIRAL CULTURE
☐ 62050 CMV Culture/IFA
☐ 62040 Measles Culture/IFA
☐ 60000 Mumps Culture/IFA
☐ 1385 Enterovirus Culture / IFA
☐ 1330 Herpes Culture / ELVIS
☐ 62000 VZV Culture / IFA
☐ 6100 Respiratory Culture / IFA
- ☐ 1375 Influenza Culture / IFA
- ☐ Other _____/IFA

☐ 60040 Viral Culture / Identification
(Please specify) _____

☐ **Gastrointestinal Outbreak Investigation**
- ☐ 60030 Rotavirus EIA
- ☐ Other _____

RABIES

(Choose nearest location)
☐ 1300 Decatur
☐ W6000 Waycross

BITE NUMBER (EPI)
BI/A# _____

Classification/Species of Animal
☐ Bat
☐ Cat
☐ Dog "Breed" _____
☐ Fox
☐ Skunk
☐ Raccoon
☐ Other: _____
☐ Pet ☐ Wild ☐ Stray

COUNTY OF ANIMAL _____
Date killed _____
Reason for testing
(mandatory, check all that apply)
☐ Human exposure
- ☐ Bite
- ☐ Contact saliva
- ☐ Scratch

☐ Domestic animal exposure
- ☐ Bite
- ☐ Contact saliva
- ☐ Scratch

☐ Epidemiological Reasons
☐ Other _____

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