



Tennessee Department of Health  
Division of Laboratory Services  
Clinical Submission Requisition

**Place State Lab Accession  
Label Here**  
(TDH use only)

**\*Indicates Required Fields**

**SPECIMEN COLLECTION INFORMATION**

*Last Name:		*First Name:	MI:
*DOB:		*Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Race: <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific islander <input type="checkbox"/> White <input type="checkbox"/> Other (_____)		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non Hispanic	
Address:			
City:	*County of Residence:	State:	Zip Code:

**SUBMITTER INFORMATION**

*Submitter:	Medical Record Number:	
Address:		
City:	State:	Zip Code:

**SPECIMEN INFORMATION**

*Date of Collection:	*Specimen Source:
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**TEST REQUESTED**

Culture	Parasitology	Serology
<input type="checkbox"/> Actinomycete (Aerobic)	<input type="checkbox"/> Blood Parasite	<input type="checkbox"/> Arbovirus Panel
<input type="checkbox"/> Aerobe	<input type="checkbox"/> Ova & Parasite	<input type="checkbox"/> HIV Screen
<input type="checkbox"/> Anaerobe	<input type="checkbox"/> Cryptosporidium	<input type="checkbox"/> Measles/Rubella IgM
<input type="checkbox"/> Enteric	<input type="checkbox"/> Giardia DFA	<input type="checkbox"/> Rickettsia Panel
<input type="checkbox"/> Gonorrhea		<input type="checkbox"/> Syphilis RPR
<input type="checkbox"/> Herpes Simplex Virus	<b>Molecular</b>	<input type="checkbox"/> VDRL
<input type="checkbox"/> Legionella	<input type="checkbox"/> <i>C.trachomatis/N.gonorrhoeae</i>	
<input type="checkbox"/> Mycobacteria Smear & Culture	(GenProbe)	<b>Miscellaneous</b>
<input type="checkbox"/> Mycobacteria Reference Isolate	<input type="checkbox"/> Norovirus PCR	<input type="checkbox"/> Bordetella (Pertussis)
<input type="checkbox"/> Mycology		<input type="checkbox"/> CRE Confirmation
<input type="checkbox"/> Viral: Virus Suspected _____		<input type="checkbox"/> Other _____

**ADDITIONAL INFORMATION**

Is this an isolate being submitted in response to the TDH Reportable Diseases and Events Guidelines?  No  Yes

Is this an isolate being submitted as part of a surveillance program?  No  Yes If yes, program name: \_\_\_\_\_

Please provide the following information with regard to isolates submitted:

Gram Stain Reaction: \_\_\_\_\_ Suspected Organism: \_\_\_\_\_

If urine, colony count: \_\_\_\_\_ If blood culture, no. of bottles positive/ no. of bottles drawn: \_\_\_\_\_

**LABORATORY FACILITIES**

Nashville Laboratory: P.O.Box 305130, Nashville, TN 37230 (USPS) OR 630 Hart Lane, Nashville, TN 37216 (FedEx, UPS, courier delivery)  
David L. Smalley, Ph.D., M.S.S., BCLD/PHLD (ABB), Director

Knoxville Laboratory: 2101 Medical Center Way, Knoxville, TN 37920 – Lisa Duncan, MD, Director

Jackson Laboratory: 295 Summar Drive, Jackson, TN 38301– Oristyne E. Walker, Ph.D., HCLD (ABB), Director