

Important Note: All specimens sent to the State Public Health Lab for measles testing **MUST** be approved by TDH prior to submission. To obtain approval, call your local health department or 615-741-7247.

What to collect

- Measles PCR
 - Throat or NP swab
 - Synthetic swab collection
 - Stored in Viral Transport Medium (VTM)
 - Each tube must be labeled with **TWO patient identifiers**
- Measles IgM
 - Whole blood
 - Red top tube
 - At least 2 mL preferred

Storage and Submission

- Specimen should be stored at **2-8°C**
- Ship on cold packs within **48 hours** of collection
- Please consult with TDH if sending **>48 hours** after collection
- A PH-4182 form will need to be submitted with each specimen
 - Under “**Test Requested**” check “**Other Miscellaneous**” and write in “**Measles PCR testing**” for swab or “**Measles-IgM**” for blood. (See Page 2 or click [here](#))

Shipping Information

- Specimens should be sent **overnight** between **Monday-Thursday**
- If a facility is a birthing hospital and has a Newborn Screening Courier Service, the specimens may be sent with the daily pickup
- Shipping address for items sent by UPS, FedEx, and carriers other than USPS:

Tennessee Department of Health
Laboratory Services
630 Hart Lane
Nashville, TN 37216-2006



Division of Laboratory Services
Clinical Submission Requisition

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

***Indicates Required Fields**

Final test reports cannot be issued if required information is missing

SPECIMEN COLLECTION INFORMATION

*Last Name:		*First Name:		MI:
*DOB:		*Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
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 (_____)				
Address:				
City:	State:	Zip Code:	Outbreak Number:	
*Date of Collection:		*Specimen Type & Source:		*County of Residence:

SUBMITTER INFORMATION

*Submitting Facility:		Patient Medical Record Number:		
Address:		Phone Number:	Fax Number:	
City:		State:	Zip Code:	
*Ordering Provider:		Phone Number:	Fax Number:	
Sample Collection Facility:		Patient Medical Record Number:		
Address:		Phone Number:	Fax Number:	
City:		State:	Zip Code:	
Point of Contact:		Phone Number:	Fax Number:	

***TEST REQUESTED**

- | | | |
|---|--|---|
| <p><u>Culture</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Actinomyceete (Aerobic) <input type="checkbox"/> Aerobe <input type="checkbox"/> Anaerobe <input type="checkbox"/> Enteric <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Herpes Simplex Virus <input type="checkbox"/> Legionella <input type="checkbox"/> Mycobacteria Smear & Culture <input type="checkbox"/> Mycobacteria Reference Isolate <input type="checkbox"/> Mycology <input type="checkbox"/> Viral: Virus Suspected _____ <input type="checkbox"/> Other Miscellaneous (Please specify) _____ | <p><u>Parasitology</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Blood Parasite <input type="checkbox"/> Ova & Parasite <input type="checkbox"/> Cryptosporidium <p><u>Serology</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Arbovirus Panel <input type="checkbox"/> HBV Screen <input type="checkbox"/> HCV Screen <input type="checkbox"/> HIV Screen <input type="checkbox"/> Measles/Rubella IgM <input type="checkbox"/> Syphilis RPR <input type="checkbox"/> VDRL | <p><u>Molecular</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Bordetella (Pertussis) PCR <input type="checkbox"/> <i>C.trachomatis/N.gonorrhoeae</i> (GenProbe) <input type="checkbox"/> GI Panel (Biofire) <input type="checkbox"/> ESBL <input type="checkbox"/> Norovirus PCR <input type="checkbox"/> Plasmodium PCR <p><u>ARLN</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> <i>C. auris</i> Colonization <input type="checkbox"/> <i>Candida</i> species Confirmation <input type="checkbox"/> CRE/CRPA/CRAB Colonization <input type="checkbox"/> CRE/CRPA/CRAB Confirmation |
|---|--|---|

ADDITIONAL INFORMATION

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

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

Please provide the following information with regard to isolates/specimens submitted:
Gram Stain Reaction: _____ Other lab tests performed and results: _____
Automated ID if applicable: _____ Suspected Organism: _____

LABORATORY FACILITIES

Nashville Laboratory: P.O.Box 305130, Nashville, TN 37230 (USPS) OR 630 Hart Lane, Nashville, TN 37216 (FedEx, UPS, courier delivery)
Richard Steece, PhD, D(ABMM), Public Health Laboratory Director Main Line: (615) 262-6300

Knoxville Regional Laboratory: 2101 Medical Center Way, Knoxville, TN 37920
George J. Dizikes, PhD, HCLD/CC (ABB), Public Health Laboratory Director Main Line: (865) 549-5201

Shelby County Health Department: 814 Jefferson Avenue, Memphis, TN 38105
Vickie Baselski, PhD, D(ABMM), Public Health Laboratory Director Main Line: (901) 222-9477