	Tennessee Department of Health 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:**	***Sex:** □ Male □ Female □ Other □ Unknown		Ethnicity: □ Hispanic □ Non-Hispanic
Race: □ American Indian □ Asian □ Black □ Hawaiian/Pacific Islander □ White □ Other (_____)			
Address:			Phone Number:
City:	***State:**	Zip Code:	Outbreak Number:
***Date of Collection:**	***Specimen Type & Source:**		***County of Residence:**

Unlabeled or mislabeled specimens cannot be tested; two distinct identifiers required on each container that match information on the requisition.

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

Culture
- □ Actinomycete (Aerobic)
- □ Aerobe
- □ Anaerobe
- □ Enteric
- □ Neisseria gonorrhoeae
- □ Legionella pneumophila
- □ Mycobacteria Smear & Culture
- □ Mycobacteria Reference Isolate
- □ Mycology

Serology
- □ Arbovirus Panel
- □ HBV Screen**
- □ HCV Screen
- □ HIV Screen
- □ Measles**
- □ Syphilis

Molecular
- □ Chlamydia trachomatis/ Neisseria gonorrhoeae
- □ GI Panel
- □ Herpes Simplex Virus
- □ Legionella PCR
- □ Measles PCR**
- □ Mumps PCR**
- □ Norovirus PCR
- □ Plasmodium PCR
- □ Rickettsia PCR

ARLN
- □ Aspergillus fumigatus AST
- □ Candida species Confirmation
- □ CRE/CRPA/CRAB Confirmation

Parasitology
- □ Blood Parasites
- □ Ova & Parasites
- □ Cryptosporidium

Other Testing (Please specify) _____

** Requires prior approval from CEDEP

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 regarding isolates/specimens submitted:
Gram Stain Reaction: _____ Other lab tests performed and results: _____
Automated ID if applicable: _____ Suspected Organism: _____

LABORATORY FACILITIES

Nashville Central Laboratory:
P.O. Box 305130, Nashville, TN 37230 (USPS) **OR**
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Main Line: (615) 262-6300
Kara Levinson, PhD, MPH, D(ABMM), Director

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