Maine Health and Environmental Testing Laboratory

47 Independence Drive, Augusta, Maine 04333-0012, Phone: 207-287-2727 Fax: 207-287-8925

This form and others available for download or printing from our website: **www.mainepublichealth.gov/lab/downloadableforms**

(*REQUIRED FIELDS)

*Submitter Name/Address Submitter Phone Submitter Fax#	Hospital/Lab ID# Physician Name (**First/Last**) Physician Address and Phone	Physician Fax Physician Practice/Affiliation Physician NPI#

***Patient Name (*Last, *First, MI)** **Is patient hospitalized?** ☐ **Yes** ☐ **No**	***Gender** ☐ M ☐ F ***Date of Birth (mm/dd/yyyy)** Symptom Onset Date	***Specimen source** ☐Anal ☐Bronch wash ☐Buccal ☐Cervical ☐CSF ☐Endocervical ☐Labial ☐Nasal/Nasal Wash	☐Nasopharyngeal ☐Penile ☐Plasma ☐Rectal ☐Serum ☐Sputum ☐Stool ☐Throat	☐Urethral ☐Urine ☐Vaginal ☐Vulva ☐Whole blood ☐Other (specify)
		***Date of Collection (mm/dd/yyyy)**		

Information highlighted above is required for ALL test requests; Blood lead testing requires additional fields

***Patient Street Address**	***Apt#**	***City/Town**	***State**	***Zip Code**
Race ☐ White ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Two or more races	Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic/Non-Latino	MaineCare (if primary) MUST include copy of MaineCare Card, otherwise facility will be charged **Blood Lead - ONLY** ☐ **Check only if patient has No Private Insurance Coverage AND No MaineCare Coverage**	**Blood Lead - Only** Parent/Guardian Name **Blood Lead - Only** Parent/Guardian Phone	

BACTERIOLOGY

- ☐ Chlamydia/Gonorrhea NAAT
- ☐ Campylobacter Identification
- ☐ Carbapenem resistance - Isolate only
- ☐ Enteric Pathogen Screen (Salmonella, E. coli, Shigella, Campylobacter)
- ☐ Haemophilus influenzae serotyping
- ☐ Listeria Identification
- ☐ Neisseria meningitidis culture
- ☐ Neisseria meningitidis serotyping
- ☐ Neisseria meningitidis PCR - CSF only
- ☐ Salmonella Identification / serotyping
- ☐ Shiga Toxin / E. coli serotyping
- ☐ Shigella Identification / serotyping
- ☐ Vibrio Identification
- ☐ Bacterial Culture Identification
  Organism suspected:
- ☐ Rule out B. anthracis or other select agent
  Please specify:

MYCOBACTERIOLOGY

- ☐ AFB Smear and Culture w/ Identification
- ☐ MTBC/MAC PCR (Requires TB Control Approval)
- ☐ Reference Culture Identification by 16S
- ☐ Susceptibility Send Out (Positives Only)

VIROLOGY

- ☐ Adenovirus RT-PCR
- ☐ Enterovirus RT-PCR
- ☐ Herpes simplex (HSV1/HSV2) RT-PCR
- ☐ Influenza A/B RT-PCR
- ☐ Mumps RT-PCR
- ☐ Norovirus RT-PCR
- ☐ Parainfluenza 1-4 RT-PCR
- ☐ Rhinovirus RT-PCR
- ☐ RSV RT-PCR
- ☐ Rubeola (Measles) RT-PCR
- ☐ SARS-CoV-2 RT PCR
- ☐ Varicella/Herpes zoster RT-PCR (chicken pox/shingles)
- ☐ **Respiratory Panel by RT-PCR** Includes: Adenovirus, Respiratory Enterovirus, Influenza A/B, Parainfluenza 1-4, RSV, Rhinovirus, and SARS-CoV-2
- ☐ **CSF Panel by RT-PCR** Includes: Enterovirus, HSV1, HSV2, VZV and Neisseria meningitidis screen
  May be Reflexed to Arbovirus IgM Panel.
  Requires 1.5 mL of spinal fluid for testing.

BLOOD LEAD

- ☐ Venous
- ☐ Venous in microtainer
- ☐ Capillary
- ☐ **Symptomatic or Repeat Test**

SEROLOGY

- ☐ Arbovirus IgM Panel **
  (WNV, SLE, EEE for serum and CSF)
  **Requires arboviral submission form
- ☐ Hepatitis C IgG Antibody screen
- ☐ HIV-1/HIV-2 Antibody/p24 Antigen screen
  (Repeatedly reactive HIV screen will reflex to HIV Confirmation and be billed accordingly)
- ☐ **Quantiferon - TB Gold Plus** - Serology
- ☐ RPR Syphilis screen
- ☐ Syphilis serum confirmation
- ☐ Syphilis VDRL, CSF only

ARBOVIRUS

- ☐ Bourbon County virus RT-PCR **
- ☐ Chikungunya virus RT-PCR **
- ☐ Dengue virus RT-PCR **
- ☐ Heartland virus RT-PCR **
- ☐ Jamestown Canyon virus RT-PCR **
- ☐ Powassan/Deer Tick virus RT-PCR **
- ☐ Zika virus RT-PCR **

**Requires arboviral submission form

ADDITIONAL INFORMATION