DEPARTMENT OF HEALTH

Submit Sample(s) to:
MN Public Health Laboratory
Infectious Disease Lab
601 Robert St. N
St. Paul, MN 55155

Phone (651) 201-5200
Fax (877) 694-4502
Specimen Receiving (651) 201-4953
CLIA# 24D0651409

*MDH Lab Use Only*
Condition:
Ambient
Refrigerated
Frozen
Barcode Sticker

# Infectious Disease Laboratory Submission Form

* Required Fields

## Submitter

*Submitting Facility: _____

*Address: _____

_____

City: _____ State: _____ Zip: _____

Name of Person Filling Out Form: _____

Phone: _____

Originating Facility: _____

Ordering Provider: _____

Project Number if Known: _____

## Patient

*Last Name: _____

*First Name: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Patient MRN #: _____ Sex: _____

*Date of Birth: (mm/dd/yyyy) _____ Ethnicity: _____

Race: _____

## Specimen

*Submitter Sample ID: _____

*Date of Collection (mm/dd/yyyy): _____

Time of Collection (##:##): _____

AM ☐ PM ☐

## Reportable Disease/Referral

### Reportable Disease Specimen (Test assigned by MDH)

Source: _____ Site: _____

CIDT Platform: _____

Organism 1: _____

Organism 2: _____

Organism 3: _____

Organism 4 / Specifiy Other: _____

### Reportable Disease Isolate (Test assigned by MDH)

Source: _____ Site: _____

Organism: _____

### Referral Testing at CDC:

CDC Test: _____

Submitting Laboratory - Specify Any Other Organism/Test Info or Comments:

## Test and Epidemiology Information

### Virology

Source: _____ Site: _____

Test Requested: _____

Date of Symptom Onset: _____

Vaccination Date: _____

### Serology

Source: _____ Site: _____

Test Requested: _____

Date of Symptom Onset: _____

Previous Result: _____

### Influenza

Source: _____ Site: _____

Test Requested: _____

Date of Symptom Onset: _____ Date of Vaccination: _____

Result/Subtype: _____ Test by Submitter: _____

### Microbiology

Source: _____ Site: _____

Test Requested: _____

*Prior MDH Notification #Prior MDH Authorization

### Mycobacteria

Source: _____ Site: _____

Test Requested: _____

AFB Isolate Media Submitted : _____

M.TB Complex PCR only Smear Result: _____

M.TB Complex PCR only Specimen Condition: _____

### Parasitology

Source: _____ Site: _____

Test Requested: _____

### Mycology

Source: _____ Site: _____

Test Requested: _____

PCR: ☐ Blasto/Histo ☐ Cocci

### Other

Source: _____ Site: _____

Test Requested: _____