**PRINT, APPLY LABEL OR STAMP: DO NOT ABBREVIATE ONLY ONE TEST PER SUBMISSION FORM**

 **Do Not Use**

 **This Space**

|  |  |
| --- | --- |
| 1. **Submitting Facility (Receives Test Result):**

\_UMASS-Marlborough Hospital\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Facility / Laboratory Name *(required)*\_\_157 Union St\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Street Address\_\_Marlborough, MA 01752\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City, State Zip\_\_\_508-486-5489\_\_\_\_\_\_\_\_508-229-1240\_\_\_\_\_\_\_\_\_\_\_\_Phone # Secure Fax #: | **2. Patient Info:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Name, First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Street Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City, State Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient ID: Phone #: |
| **4. Sex:** M F Other **DOB:\_\_\_\_\_\_\_\_\_** |
| **5. Race:** (Check One)* American Indian or Alaska Native Asian
* Black or African American White
* Native Hawaiian or Pacific Islander Other
 |
| 1. **Ordering Clinician/ Phone# *(required)*:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Clinician Name (*First and Last Name)* Phone number# |
| **6. Ethnicity:** Hispanic or Latino Non-Hispanic or Latino |

**Test Requested: Collection Date: Date of Onset:**

**\_\_\_\_\_COVID-19\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(required) One Per Form (required) One Per Form (required)

|  |  |  |
| --- | --- | --- |
| **Serology** |  | **Culture** |
|  | Acute |  | Contact |  | Test of Cure |  | Date of Culture:  |
|  | Confirmation |  | Surveillance |  |  |  | Date of Subculture: |
|  | Convalescent |  | Symptomatic |  |  |  | Sample Treated Y N If yes, how:  |

**Source of Specimen: (required) One Per Form**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Anal canal |  | Nasopharynx |  | Stool |  | Body Fluid (site) |
|  | Blood |  | Plasma |  | Throat (pharynx) |  | Bronchus (site) |
|  | Bone Marrow |  | Serum |  | Urethra |  | Exudates (site) |
|  | Cervix |  | Spinal Fluid |  | Urine |  | Wound (site) |
|  | Gastric |  | Sputum |  |  |  | Tissue (site) |
|  | Other: (Specify) |
|  |  |

**Additional Patient Information:**

|  |
| --- |
| Symptoms, and Duration |
| Travel History (Dates and Locations) |
| Animal / Insect contact: (specify) |
| Relevant Immunizations (Dates) |
| Previous Laboratory Results |

**Please fill out “Additional Patient Information” section on front of form for the following tests:**

|  |  |  |
| --- | --- | --- |
| Adenovirus  | Herpes | Rickettsia |
| Arbovirus testing | Influenza | Respiratory Synctial virus (RSV) |
| Babesia | Lymphocytic choriomeningitis virus (LCM) | Rubella |
| Campylobacter | Legionella | Salmonella |
| Chikungunya | Lyme Disease | Shigella |
| Cytomegalovirus (CMV) | Measles | St. Louis Encephalitis |
| Dengue Fever | Mumps | Syphilis |
| E. coli | *Mycoplasma pneumoniae* | Vaccinia virus |
| Eastern Equine Encephalitis | Parainfluenza | Varicella zoster |
| Enterovirus | Parasitology serology | Vibrio |
| Ehrlichia | Pertussis | West Nile Virus |
| Hantavirus | Q Fever | Yellow Fever |