**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 |