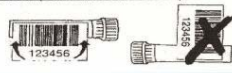











Kansas Health and Environmental Laboratories – Universal Laboratory Specimen Submission Form (Test Requisition) Guide

Front Page

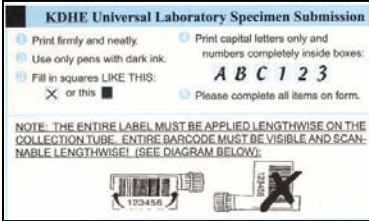
KDHE Universal Laboratory Specimen Submission Form (Health)		Page 1
<p>1 Print firmly and neatly. 1 Print capital letters only and numbers completely inside boxes:</p> <p>2 Use only pens with dark ink.</p> <p>3 Fill in squares LIKE THIS: A B C 1 2 3</p> <p style="text-align: center;"><input checked="" type="checkbox"/> or this <input type="checkbox"/></p> <p>4 Please complete all items on form.</p> <p>NOTE: THE ENTIRE LABEL MUST BE APPLIED LENGTHWISE ON THE COLLECTION TUBE. ENTIRE BARCODE MUST BE VISIBLE AND SCANNABLE LENGTHWISE! (SEE DIAGRAM BELOW):</p> 	 4222594  4222594  4222594  4222594  4222594  4222594  4222594	
PROVIDER INFORMATION:		
FACILITY ID _____		PHYSICIAN'S LAST NAME _____
PATIENT INFORMATION:		
PATIENT'S LAST NAME _____		KDHE Approved Label Only Affix 4" x 1" Label Upright and Level!! Call (785) 296-1620 for Information
PATIENT'S FIRST NAME _____		
PATIENT'S CODE _____	SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE _____ CO OF RES _____
MEDICAID NUMBER _____	RACE <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> AI, AN <input type="checkbox"/> Black <input type="checkbox"/> HN, PI <input type="checkbox"/> Non-Hispanic or Non-Latino	ETHNICITY <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Non-Latino
SAMPLE INFORMATION:		
DATE OF COLLECTION _____	DATE OF ONSET _____	PATIENT SYMPTOMS <input type="checkbox"/> Yes <input type="checkbox"/> No
CLINIC SOURCE <input type="checkbox"/> Adolescent <input type="checkbox"/> Prison <input type="checkbox"/> C & T <input type="checkbox"/> University <input type="checkbox"/> Drug <input type="checkbox"/> STD <input type="checkbox"/> FP <input type="checkbox"/> TB <input type="checkbox"/> M & I <input type="checkbox"/> Other* <input type="checkbox"/> Prenatal	SPECIMEN TYPE <input type="checkbox"/> Blood <input type="checkbox"/> Plasma <input type="checkbox"/> Urine <input type="checkbox"/> Pericardial Fluid <input type="checkbox"/> Bronchial <input type="checkbox"/> Serum <input type="checkbox"/> Urethral <input type="checkbox"/> Peritoneal Fluid <input type="checkbox"/> CSF <input type="checkbox"/> Sputum <input type="checkbox"/> Vaginal <input type="checkbox"/> Pleural Fluid <input type="checkbox"/> Endocervical <input type="checkbox"/> Stool <input type="checkbox"/> Wound <input type="checkbox"/> Synovial Fluid <input type="checkbox"/> Genital <input type="checkbox"/> Throat <input type="checkbox"/> Other* <input type="checkbox"/> Thoracentesis Fluid <input type="checkbox"/> Nasopharyngeal <input type="checkbox"/> Tissue *Specify _____	
ACUTE SERUM _____	CONVALESCENT SERUM _____	
DO NOT WRITE IN THE SPACE BELOW - DO NOT PHOTOCOPY THIS FORM		
Kansas Department of Health and Environment Division of Health & Environmental Laboratories Forbes Field, Building 740, Topeka, KS 66620 CLIA #17D0648254 Phone (785) 296-1620 Fax (785) 296-1641		 4222594

Back Page

KDHE Universal Laboratory Specimen Submission Form (Health)		Page 2
TEST INFORMATION/REQUEST		
HIV Serology Risk Code _____ Ref Code _____ Prior Confirmation <input type="checkbox"/> Yes <input type="checkbox"/> No Specimen Initial Specimen Repeat <input type="checkbox"/> Referral <input type="checkbox"/> Test Purpose <input type="checkbox"/> Diagnosis <input type="checkbox"/> Other <input type="checkbox"/> Prenatal		
Hepatitis <i>If a HBsAG is requested with another serology test, 5 ml of serum or 2 tubes of blood must be submitted (HAV, HCV, HIV, RUB, SYPH, etc.)</i> HAV-IgM <input type="checkbox"/> Exposure Risk <input type="checkbox"/> HCV-IgG <input type="checkbox"/> IVDU History/Sexual Partner <input type="checkbox"/> HBsAG <input type="checkbox"/> Household Contact & Prenatal <input type="checkbox"/> Sexual Contact <input type="checkbox"/> Other Assays _____	Other Serological Assays <input type="checkbox"/> IgM <input type="checkbox"/> Vaccine Preventable <input type="checkbox"/> IgG <input type="checkbox"/> Other <input type="checkbox"/> CSF <input type="checkbox"/> Specify _____	
Syphilis Serology Test Purpose <input type="checkbox"/> Diagnosis <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Prenatal <input type="checkbox"/> Other Clinical Information <input type="checkbox"/> Late Syphilis Symptoms <input type="checkbox"/> Treatment Control Prior Reagin Reactive Test <input type="checkbox"/> RPR, RST or VDRL Test Date 1) _____ 2) _____	Rubella <input type="checkbox"/> Immune Status/Prenatal <input type="checkbox"/> Diagnosis <input type="checkbox"/> Date of Exposure _____	
Nucleic Acid Amplified Tests for Chlamydia and Gonorrhea Exam Purpose <input type="checkbox"/> Comp FP Exam <input type="checkbox"/> PN Exam <input type="checkbox"/> STD Exam <input type="checkbox"/> Repeat Clinical Observations <input type="checkbox"/> Cervicitis <input type="checkbox"/> Urethritis <input type="checkbox"/> PID-Like <input type="checkbox"/> None Risk History <input type="checkbox"/> Friable <input type="checkbox"/> New Partner <input type="checkbox"/> Multiple Partners <input type="checkbox"/> Contact of STD Case	Pertussis <input type="checkbox"/> PCR <input type="checkbox"/> Other _____	
Viral Cultures Specimen <input type="checkbox"/> ID <input type="checkbox"/> Culture Material <input type="checkbox"/> Swab <input type="checkbox"/> Biopsy <input type="checkbox"/> Autopsy Body Fluid <input type="checkbox"/>	Viral Syndrome Observed <input type="checkbox"/> Gastroenteritis <input type="checkbox"/> Ocular <input type="checkbox"/> Vesicles <input type="checkbox"/> Genital Lesion <input type="checkbox"/> Respiratory <input type="checkbox"/> Specific Viral Agents <input type="checkbox"/> Vaccine Preventable Disease <input type="checkbox"/> Neurological <input type="checkbox"/> Specify _____	
Blood Lead <input type="checkbox"/> Capillary <input type="checkbox"/> Venous <input type="checkbox"/> Repeat Specimen Patient Address Required for Blood Lead Specimens Patient Address _____ City State, Zip _____		
Bacteriology Culture <input type="checkbox"/> Enteric Screen <input type="checkbox"/> R/O Other Enteric Organisms Specify _____ <input type="checkbox"/> Bacterial Identification Suspected <input type="checkbox"/> Gonorrhea Culture (non-genital/legal)	Parasitology <input type="checkbox"/> Intestinal Parasite (Not Cryptosporidium) <input type="checkbox"/> Non-Fecal Specimen Specify _____ <input type="checkbox"/> R/O Cryptosporidium (Patient Condition should include one of the following): <input type="checkbox"/> Watery Diarrhea <input type="checkbox"/> Arthropod/Insect ID <input type="checkbox"/> Institution Resident <input type="checkbox"/> Pinworm Exam (Co. Health Dept. Only) <input type="checkbox"/> Immune Suppressed <input type="checkbox"/> < 5 Years Old	
Tuberculosis <input type="checkbox"/> Culture w/Smear <input type="checkbox"/> Mycobacterium Isolate for ID		
CDC Provided Tests Specify _____	Submitter Comments _____	
DO NOT WRITE IN THE SPACE BELOW - DO NOT PHOTOCOPY THIS FORM		
Kansas Department of Health and Environment Division of Health & Environmental Laboratories Forbes Field, Building 740, Topeka, KS 66620 CLIA #17D0648254 Phone (785) 296-1620 Fax (785) 296-1641		 4222594

Kansas Health and Environmental Laboratories – Universal Laboratory Specimen Submission Form (Test Requisition) Guide

1



KDHE Universal Laboratory Specimen Submission Form (Health)

- Print capital letters only and numbers completely inside boxes.
- Print firmly and neatly.
- Use only pens with dark ink.
- Fill in squares LIKE THIS: or this
- Please complete all items on form.

NOTE: THE ENTIRE LABEL MUST BE APPLIED LENGTHWISE ON THE COLLECTION TUBE. ENTIRE BARCODE MUST BE VISIBLE AND SCANNABLE LENGTHWISE! (SEE DIAGRAM BELOW)

1) Carefully read and follow the instructions found on page 1 (front page), of the Universal Laboratory Specimen Submission Form (Universal Form).

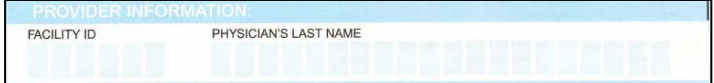
2



Form (Health) Page 1

2) Place a Barcode Sticker on your specimen(s) primary receptacle and keep one sticker for your records.

3



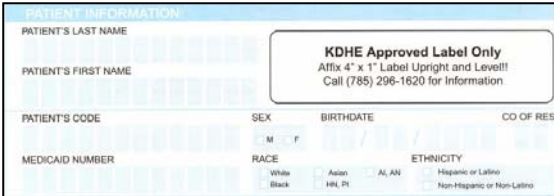
PROVIDER INFORMATION:

FACILITY ID PHYSICIAN'S LAST NAME

3) Fill in your KHEL Facility ID number and requesting Physician's last name in the Provider Information Section.

The Facility ID number determines where patient results will be sent. The number must be entered correctly.

4



PATIENT INFORMATION:

PATIENT'S LAST NAME

PATIENT'S FIRST NAME

PATIENT'S CODE SEX BIRTHDATE CO OF RES

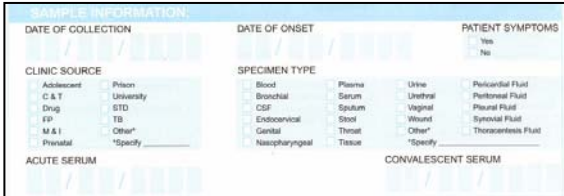
MEDICAID NUMBER RACE ETHNICITY

White, Black, Asian, AI, AN, Hispanic or Latino, NH, PI, Non-Hispanic or Non-Latino

KDHE Approved Label Only
Affix 4" x 1" Label Upright and Level!!
Call (785) 296-1620 for information

4) Fill in the Patient's last name, first name, code (code is optional and is for the patients use, not for KHEL), Medicaid number, sex, DOB, county of residence, race, and ethnicity in the Patient Information Section.

5



SAMPLE INFORMATION:


DATE OF COLLECTION DATE OF ONSET PATIENT SYMPTOMS

CLINIC SOURCE SPECIMEN TYPE

ACUTE SERUM CONVALESCENT SERUM

5) Fill in the date of collection, date of onset, patient symptoms, clinic source, and specimen type in the Sample Information Section. If applicable, fill in the Date of Onset, Acute or Convalescent serum sections.

6




Page 2

6) Select the required tests on page 2 (back page) of the Universal Form.

Note: If selecting blood lead, patient address must be filled in.

7



Submitter Comments

THE SPACE BELOW - DO NOT PHOTOCOPY THIS FORM

7) If you have additional comments important to your specimen, write them in the Submitter Comments Section.

- Each form number is unique and assigned to you. **DO NOT** photocopy the Universal Form.
- Mark all applicable areas completely.
- If you do not know your facility ID, call the Lab at: (785) 296-1620.
- Place completed submission form inside fibreboard shipper **outside of secondary container.**
- Universal Forms checked out by your facility may only be used by your facility. Please do not share with other facilities.