



**DHEC 1335 Submission Form**  
 DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL  
 Public Health Laboratory  
 8231 Parklane Road Columbia, SC 29223  
 (803) 896-0800

CLIA#42D0658606

**ALIGN BARCODE LABEL  
TO TOP OF BOX**

<b>Patient's Name (Last)</b>	<b>(First)</b>	<b>(MI)</b>	<b>Sex</b>	<b>Ethnicity</b>	<b>Race</b>	<b>Date of Birth</b>
<b>Address</b>			<b>City</b>	<b>State</b>	<b>Zip Code</b>	<b>County of Residence</b>
<b>Phone Number</b>	<b>Country of Birth</b>	<b>MCI Number</b>		<b>Local ID</b>	<b>Provider NPI</b>	

<b>Sender No.</b> 614	<b>Sender Name</b> ABBEVILLE AREA HEALTHCARE CENTER G00338	<b>Billing Number</b>	<b>Program No.</b>	<b>Outbreak Number</b>
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<b>Ordering Physician, Provider and/or Nurse:</b>	<b>Clinical Diagnosis</b>
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**Special Instructions and/or Comments:** Please place your email here for e-mailed results.

<b>Specimen Information</b>	<b>Date of Onset</b>	<b>Agents/Organisms/or Virus Suspected</b>
<b>Collection Date:</b>	<b>Collection Time:</b> <input type="checkbox"/> AM <input type="checkbox"/> PM	

**Specimen Type/Source**

<input type="checkbox"/> Blood/Serum	<input type="checkbox"/> Throat swab	<input type="checkbox"/> Genital _____	<b>Mycobacteriology Specimens</b> <input type="checkbox"/> Induced sputum <input type="checkbox"/> Spontaneous sputum <input type="checkbox"/> Other _____
<input type="checkbox"/> Bronchial wash	<input type="checkbox"/> Urine	<input type="checkbox"/> Swab _____	
<input type="checkbox"/> Nasopharyngeal Swab	<input type="checkbox"/> Wound pus drainage	<input type="checkbox"/> Tissue/Biopsy _____	
<input type="checkbox"/> Smear (Do not mark for TB)	<input type="checkbox"/> BAL	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Stool specimens	<input type="checkbox"/> Nasal Swab		

**Symptoms**

<input type="checkbox"/> Arthralgia/Myalgia	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Rash Type: _____
<input type="checkbox"/> Asymptomatic	<input type="checkbox"/> Encephalitis	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Respiratory
<input type="checkbox"/> Conjunctivitis	<input type="checkbox"/> Fever	<input type="checkbox"/> Pleurodynia	<input type="checkbox"/> Other

**Test Requested**

**Clinical Microbiology (Bacteriology/Parasitology)**

Was culture incubated before transport:  Yes  No  24 hours  48 hours

<input type="checkbox"/> Broth Specimen for Shiga toxin producing E. coli	<input type="checkbox"/> Culture/Isolate for Shiga toxin producing E. coli	<input type="checkbox"/> Legionella Urine Antigen
<input type="checkbox"/> CRE/CRPA/CRAB	<input type="checkbox"/> Enteric Culture	<input type="checkbox"/> Non-Enteric Culture and ID
<input type="checkbox"/> Candida ID	<input type="checkbox"/> GC Culture and ID	<input type="checkbox"/> Organism for ID-Aerobic
<input type="checkbox"/> Cryptosporidium Antigen		<input type="checkbox"/> Other _____

**Mycobacteriology**

Known TB case? <input type="checkbox"/> Yes <input type="checkbox"/> No	R/O new TB Case? <input type="checkbox"/> Yes <input type="checkbox"/> No	Suspicious hx, s/sx? <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Rx? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Clinical Specimen for ID and Smear	<input type="checkbox"/> Drug Susceptibility:	<input type="checkbox"/> Specimen for Genotyping	
<input type="checkbox"/> Isolate for ID <input type="checkbox"/> Blood Culture	<input type="checkbox"/> Clinical Specimen <input type="checkbox"/> Referred Isolate		

**Virology**

<input type="checkbox"/> BioFire Respiratory Panel (Outbreak Only)	<input type="checkbox"/> Herpes	COVID RT-PCR	Y	N	U		Y	N	U
<input type="checkbox"/> Bordetella (BioFire)	<input type="checkbox"/> Measles RT-PCR	First Test?				Hospitalized?			
<input type="checkbox"/> GI Outbreak (Norovirus RT-PCR and/or Biofire GI panel)	<input type="checkbox"/> Mumps RT-PCR	Employed in healthcare?				ICU?			
<input type="checkbox"/> Influenza RT-PCR In-patient Out-Patient	<input type="checkbox"/> Triplex RT-PCR	Symptomatic (CDC defined)?				Pregnant?			
<input type="checkbox"/> QuantiFeron TB-Gold Plus Incubation Start Time:	End Time:	Resident in a congregate care facility?							

**Special Pathogens**

<b>Rule-out Testing</b>	<b>Molecular Testing for Viral Pathogens</b>	<b>Serological Testing</b>
<input type="checkbox"/> Bacterial Isolate <input type="checkbox"/> Clinical Specimen Suspect Agent: _____	<input type="checkbox"/> Avian Influenza <input type="checkbox"/> Ebola <input type="checkbox"/> MERS <input type="checkbox"/> Other	<input type="checkbox"/> BMAT <input type="checkbox"/> Malaria

