

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

MDH Lab Use OnlyCondition:BarcodeAmbientBarcodeRefrigeratedStickerFrozenFrozen

Infectious Disease Laboratory Submission Form

	*Required Fields *Submitting Facility:		Virology
	*Address:		Source: Site:
ubmitter			Test Requested:
	City: State: Zip:		Date of Symptom Onset:
	Name of Person Filling Out Form:		Vaccination Date:
	Phone:		Serology
ร	Originating Facility:		
	Ordering Provider:		Source: Site:
	Project Number if Known:		Test Requested:
Patient	*Last Name:		Date of Symptom Onset:
	*First Name:		Previous Result:
	Address:	c	Influenza
		ation	Source: Site:
	City: State: Zip:		Test Requested:
	Patient MRN #: Sex:	form	Date of Symptom Onset: Date of Vaccination:
	*Date of Birth: (mm/dd/yyyy) Ethnicity:	Ifo	Result/Subtype: Test by Submitter:
	Race:	/ Ir	Microbiology
en	*Submitter Sample ID:	miology	Source: Site:
me	*Date of Collection (mm/dd/yyyy):	0	Test Requested:
Ū.	Time of Collection (##:##):	Е	*Prior MDH Notification #Prior MDH Authorization
pe	AM PM	pideı	Mycobacteria
		Epi	Source: Site:
ື່ລ	Reportable Disease Specimen (Test assigned by MDH)	σ	Test Requested:
eri	Source: Site:	an	AFB Isolate Media Submitted :
ef	CIDT Platform:	est	M.TB Complex PCR only Smear Result:
R H	Organism 1:	Te	M.TB Complex PCR only Specimen Condition:
Disease	Organism 2:		Parasitology
Se	Organism 3:		Source: Site:
D	Organism 4 / Specifiy Other:		Test Requested:
e	Reportable Disease Isolate (Test assigned by MDH)		Mycology
ap	Source: Site:		Source: Site:
t o	Organism:		Test Requested:
Reportable	Referral Testing at CDC:		Probe: Blasto Histo Cocci
Ř	CDC Test:		Other
Su	bmitting Laboratory - Specify Any Other Organism/Test Info or Comments:		
			Source: Site:
			Test Requested: