



Ohio Department of Health Laboratory
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Microbiology Specimen Submission Form

Note: Fields marked with an asterisk (*) must be completed. Please print.

Section 1: Patient Information

Patient Name* (Last, First, MI)		Date of Birth* (mm/dd/year)	
Address		County	Sex* <input type="checkbox"/> Female <input type="checkbox"/> Male
City	State	Zip	Chart or* Patient ID#

Section 2: Submitter Information

Agency* Name NATIONAL CHURCH RESIDENCES PARRT PROGRAM		Contact* Name PARRT CALL CENTER	
Address 2245 NORTH BANK DRIVE		Fax* Number 877-582-4873	
City COLUMBUS	State OH	Zip 43220	Phone* Number 888-344-9222

Section 3: Specimen Information (Complete all that apply)

Collection* Date	Onset* Date	ODH Outbreak#
Specimen* Type <input checked="" type="checkbox"/> Clinical <input type="checkbox"/> Isolate	Submitter* Specimen ID#	Agent* Suspected COVID-19
*Specimen Site (Check all that apply)		
<input type="checkbox"/> Abscess-Specify (<input type="checkbox"/> Aspirate <input type="checkbox"/> Swab)	<input checked="" type="checkbox"/> Respiratory, Upper-Specify (<input checked="" type="checkbox"/> NP swab <input type="checkbox"/> OP swab)	<input type="checkbox"/> Tissue-Specify: _____
<input type="checkbox"/> Blood-Specify (<input type="checkbox"/> Plasma <input type="checkbox"/> Whole)	<input type="checkbox"/> Respiratory, Lower-Specify Below: <input type="checkbox"/> Sputum (<input type="checkbox"/> Induced <input type="checkbox"/> Expecterated) <input type="checkbox"/> BAL <input type="checkbox"/> TA For mycobacteria only: <input type="checkbox"/> Processed <input type="checkbox"/> Unprocessed	<input type="checkbox"/> Urine
<input type="checkbox"/> Body Fluid-Specify Below: <input type="checkbox"/> CSF <input type="checkbox"/> Other: _____	<input type="checkbox"/> Stool-Specify Below: <input type="checkbox"/> Cary Blair <input type="checkbox"/> Enteric Broth <input type="checkbox"/> 10% Formalin <input type="checkbox"/> Bulk	<input type="checkbox"/> Wound-Specify: _____
<input type="checkbox"/> Serum-Specify (<input type="checkbox"/> Acute <input type="checkbox"/> Conv.)		<input type="checkbox"/> Other: _____

Section 4: Exam Requested (Check all that apply) **ODH approval required prior to submission; Contact 614-995-5599

Microbiology			
<input type="checkbox"/> Biothreat Agent-Specify Below:	<input type="checkbox"/> <i>Clostridium botulinum</i> **	<input type="checkbox"/> <i>Neisseria meningitidis</i>	<input type="checkbox"/> <i>Shigella</i>
	<input type="checkbox"/> Enteric Pathogen Panel**	<input type="checkbox"/> Norovirus**	<input type="checkbox"/> <i>Vibrio</i>
<input type="checkbox"/> Bacterial Strain Typing**	<input type="checkbox"/> <i>Escherichia coli</i> (STEC)	<input type="checkbox"/> <i>Salmonella</i>	<input type="checkbox"/> <i>Yersinia</i>
<input type="checkbox"/> <i>Campylobacter</i>	<input type="checkbox"/> <i>Listeria monocytogenes</i>	<input type="checkbox"/> Other:	
Mycobacteriology			
<input type="checkbox"/> Mycobacterial Smear and Culture	<input type="checkbox"/> <i>M. tuberculosis</i> Nucleic Acid Amplification (NAA)	<input type="checkbox"/> <i>M. tuberculosis</i> , Genotyping only	
<input type="checkbox"/> Mycobacterial Identification	<input type="checkbox"/> <i>M. tuberculosis</i> Susceptibility Testing (SM, INH, RIF, EMB, PZA)	<input type="checkbox"/> Other:	
Parasitology		Virology	
<input type="checkbox"/> <i>Cryptosporidium</i>	<input type="checkbox"/> <i>Giardia</i>	<input type="checkbox"/> Other:	<input type="checkbox"/> Respiratory Virus
			<input type="checkbox"/> Other:

Comments: ODH EPI APPROVAL CODE: _____	For Use by the Ohio Department of Health Laboratory Only	
	Date Received	Date Reported
	Fee Due MI	
	Exemption	