

570 East Woodrow Wilson Jackson, MS 39216

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CLIA #: 25D1096223

Clinical Specimen Submission Requisition

Please make sure the information on the form is legible and complete.

SUBMITTER INFORMATION	PATIENT INFORMATION						
Patient ID Number			PATIENT NAME Last	First	First		Suffix
			a				
Submitting Facility			County of Residence Date of Birth				
Street Address			Address				
City	State	Zip	City	State	,	Zip Co	ode
Cample Callestian Facility (if the Land Callestian Facility (if							
Sample Collection Facility (if not submitting facility)			Specimen Source Race Sex				
Name:			American Indian Male				
Address:			Asian Female				
City: State:			Black Ethnicity				
Point of Contact:			Pacific Islander Hispanic White Non-Hispanic				
Specimen Type and Date of Collection			Additional Information				
			Is this an isolate/specimen being submitted in response to the				
Primary Isolate Date of Collection: / /			MSDH Reportable Diseases Requirements?				
			No Yes				
Specimen Source							
Abscess, specify Blood, whole Bronchial Wash					Bronchial	Lavage	CSF
Biopsy, specify	Plasma Sputum Stool Urine Serum						
			Swab, specify				
Tissue, specify Wound, specify							
Other							
	Reques		ted Test				
Bacteriology (Specify agent) Enteric Culture		Mycobacteriology Mycobacteria Smear and Culture		Molecular (Epi approval required) Bordetella (Pertussis) PCR			
Below:			Mumps PCR				
Enteric Isolate		Pulmonary TE		GI Biofire			
STEC Listeria Salmonella spp Shigella			-TB therapy for less	Respiratory Biofire			
Salmonella typhi Vibrio		than 3 days. asitology		Meningitis/Encephalitis			
Miscellaneous Isolate]	Blood Parasite		Biofire Varicella Zoster Virus			
Clostridium botulinum		Ova & Parasite		(patients > 15 years of age)			
Neisseria meningitidis		Giardia/Cryptospo ology	oridium	STI (MSDH approved sites only)			
Haemophilus influenzae (normally sterile sites only)		West Nile Virus, I	La Crosse IgM	HIV Screening			
Grimontia hollisae	D	ate of symptom or	n-set	C.trachomatis/N.gonorrhoeae NAAT			
Photobacterium damselae		ravel History?	Yes No	Syphilis serology (check below) Symptom History			
Streptococcus pneumoniae If Yes, Where?			inya and Zika IgM Previous Reactive Test				
Other			i approval required)		ontact to syph		
	_ 1	Mumps IgG (Epi a	Rule out neurosyphilis				

Mississippi State Department of Health Form Instructions

CLINICAL SPECIMEN SUBMISSION REQUISITION

FORM NUMBER F-1252

REVISION DATE 08/06/2021

RETENTION PERIOD The MSDH Laboratory will retain the original form in accordance with

Clinical Laboratory Improvement Amendments (CLIA) regulations

PURPOSE

To collect submitter information, patient demographics and specimen information for specimens submitted from clinical laboratories for testing.

INSTRUCTIONS

Submitter Information- Left hand side of requisition

Record all requested information

Patient ID Number: Enter the submitter's patient identification number. Submitter Name: Enter the submitting facility's full name.

Street Address: Enter the submitting facility's street addressCity: Enter the submitting facility's city

State: Enter the submitting facility's state Zip: Enter the submitting facility's zip code

Phone Number: Enter the submitting facility's phone number

Contact Name: Enter the name of the submitting facility's contact if applicable Contact: Enter the phone

number of the submitting facility's contact if applicable

Patient Information - Right hand of requisition

Patient Name- Enter the patient's LAST NAME, FIRST NAME, MIDDLE INITIAL and SUFFIXin sequence.

The spelling of the patient's name on the laboratory slip and the specimen container/tube must be identical.

Name listed must be legal name; DO NOT use nicknames.

County of Residence- Enter the county where the patient currently resides (Hinds, Rankin, etc.).

Date of Birth- Provide in MM/DD/YY format.

Address - Enter the complete address where the patient currently resides.

City - Enter the name of the city in which the patient resides.

State - Enter the state in which the patient resides.

Zip Code - Enter the Zip Code of the patient's address.

Phone Number – Enter patient's telephone number including area code.

Specimen Type and Date of Collection: Mark primary or isolate for the type specimen being submitted.

Provide the Date of collection in MM/DD/YY format.

Specimen Source: Select the source of the specimen. If other, write in the source.

Test Requested: Check the box by the appropriate test requested. If other, write in the requested test.

Race – Check the box associated with the patient's race.

Ethnicity- Check the appropriate box.

Gender- Check the appropriate box (male or female)

Sample Collection Facility (if not submitting facility:

Record all requested information about the facility where original specimen was collected (i.e. nursing home, clinic,etc.).

Specimen Type, Date of Collection, Specimen Source, Additional information and Requested Test:

Provide all applicable information requested or check appropriate box.

OFFICE MECHANICS AND FILING

This form must accompany each patient for whom specimens are submitted to the MSDH Laboratory. A copy should be retained by the submitter as documentation of submission. Test results will be reported via computer generated report and forwarded to the submitter.