Specimen Type: Check appropriate specimen and fill in requested information (Only one sample per form).

- ☐ Serum (red top or SST)
  - ☐ 1st Specimen - Acute
  - ☐ 2nd Specimen - Convalescent (14-21 days after onset)
- ☐ CSF
- ▼ QuantiFERON TB Gold (3 Tubes)
  - ☐ Not Incubated (To be received within 10 hours)
  - ☐ Incubated (To be received within 3 days)

Start Date: ____ / ____ / ____ (mm dd year)

Time _____ Temp: _____

Stop Date: ____ / ____ / ____ (mm dd year)

Time _____ Temp: _____

COLLECTED: ____ / ____ / ____ (mm dd year) ____ : ____ (hh mm)

PATIENT: _____ (last) _____ (first)

BIRTH DATE: ____ / ____ / ____ (mm dd year) SSN #: ___ – ___ – ____

ADDRESS: _____

CITY: _____ STATE: ____ ZIP: _____

PHONE: ( ) - GENDER: ☐ Female ☐ Male

RACE: ☐ White ☐ Black ☐ Asian ☐ American Indian / Alaskan Native ☐ Native Hawaiian / Pacific Islander ☐ Unknown

ETHNICITY: ☐ Hispanic ☐ Non Hispanic ☐ Unknown

PATIENT ID #: _____

CLINICIAN: _____ (please print last first) CLINICIAN ID #: _____

PHONE: ( ) - CLINICIAN'S Signature:

☐ As the clinician providing care to this patient, I request that this test be performed without charge to this patient because of the imminent and significant public health threat posed by the differential diagnosis.

Serology / QuantiFERON TB Gold Test Request Form

Required Information

Syphilis
- ☐ VDRL
- ☐ TPPA (Confirmatory test for VDRL)
- ☐ FTA-ABS (CSF only or special request)

☐ QuantiFERON TB Gold
(Call UHL 24 hours prior to collection)

Relevant QFTG Information
- ☐ Contact to TB Case

Tuberculin Skin Test Result
- ☐ Positive
- ☐ Negative
- ☐ Unknown
- ☐ Not Done

Fungal
- ☐ Aspergillus Antibody Panel
- ▼ Fungal Serology Panel
  - ☐ Blastomyces
  - ☐ Coccidioides
  - ☐ Histoplasma

☐ TORCH Panel
- ☐ Cytomegalovirus (CMV) IgM
- ☐ Herpes Simplex Virus Antibody Panel
  - ☐ HSV IgG 1, HSV IgG 2
  - ☐ HSV IgM (1/2)
- ☐ Rubella Antibody Panel
  - ☐ Rubella IgG
  - ☐ Rubella IgM
- ☐ Toxoplasma Antibody (Total) (Positive Reflexed to Toxo IgM Antibody)

Hepatitis
- ☐ Hepatitis A IgM Antibody
- ☐ Hepatitis B Surface Antigen
- ☐ Hepatitis B Surface Antibody (Total)
- ☐ Hepatitis B Core IgM Antibody
- ☐ Hepatitis C IgG Antibody

Miscellaneous
- ☐ Arbovirus IgM Panel (WEE,EEE, SLE,LAC)
- ☐ Brucella Antibody (Total)
- ☐ Cryptococcal Antigen
- ☐ EBV IgG Panel (VCA, EBNA)
- ☐ Ehrlichia (HGA, HME) IgG
- ☐ Hantavirus Antibody Panel (IgG,IgM)
- ☐ Legionella Antibody (Total)
- ☐ Leptospira IgM Antibody
- ☐ Lyme Antibody (Total) (Positive Reflexed to Western Blot)
- ☐ Mumps IgM Antibody
- ☐ Parvovirus Antibody Panel (IgG, IgM)
- ☐ Picornavirus Antibody (Total) (Echo, Entero, Coxsackie)
- ☐ Q Fever IgG Antibody
- ☐ Rocky Mountain Spotted Fever IgG Antibody
- ☐ Rubeola (measles) IgM Antibody
- ☐ Tularemia Antibody (Total)
- ☐ West Nile Virus IgM Antibody

☐ Tests for CDC (Call UHL First)

MEDICAID / MEDICARE INFORMATION

Patient's Medicaid/Medicare #: _____

Physician Provider #: _____

Patient's Medicaid/Medicare ICD9 Code: _____

Referring Physician # (Medipass only): _____

If insurance is primary to Medicaid / Medicare

Insured's Name: _____ (please print)

Insured's ID#: _____

Insurance Company Name: _____

Insurance Company Address: _____

City: _____ State: ____ Zip: _____

Patient History

☐ Maternal HBV

Clinical Diagnosis: _____

Date of Onset: ____ / ____ / ____ (mm dd year)

Place IDPH Label Here

Facility Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Enter your facility address
Results are returned
to this address

University Hygienic Laboratory

102 Oakdale Campus, #101 OH
Iowa City, IA 52242-5002
Phone #: 319-335-4500
Fax #: 319-335-4555

Iowa Laboratories Complex
2220 S. Ankeny Blvd, Ankeny, IA 50021
Phone #: 515-725-1600
Fax #: 515-725-1642

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