FACILITIES, PLACE YOUR PATIENT INFORMATION LABEL HERE OR COMPLETELY FILL OUT INFORMATION BELOW

State Hygienic Laboratory at the University of Iowa

U of I Research Park
2490 Crosspark Road
Coralville, IA 52241-4721
Phone # 319-335-4500 or 800-421-IOWA

Ankeny Laboratory
2220 S. Ankeny Blvd.
Ankeny, IA 50023-9093
Phone # 515-725-1600

Lakeside Laboratory
1838 Highway 86
Milford, IA 51351-7267
Phone # 712-337-3669

http://www.shl.uiowa.edu

Viral and Bacterial PCR Test Request Form

PATIENT INFORMATION **Sample must have two patient identifiers that match this form.**

Client Reference (Patient ID/MRN/Chart ID) _____ Last Name _____ First Name _____ Birth Date ___/___/___

Address _____ City _____ State ____ Zip Code _____ Area Code/Phone # _____

Gender ☐ Female ☐ Male ☐ Unknown

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

Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

INSURANCE: SHL does not participate in private insurance. To have SHL bill public insurance, check the appropriate box and enter the patient's Insurance ID#, Diagnosis Code, and provider information.

Public Insurance: ☐ Medicaid ☐ Medicare ☐ Amerigroup Iowa MCO ☐ Iowa Total Care MCO

Insurance ID# _____ Diagnosis Code _____

ORDERING HEALTH CARE PROVIDER INFORMATION

Last Name _____ First Name _____ NPI _____ Area Code/Phone # _____

ORGANIZATION INFORMATION (Results are reported to this address. Organizations are responsible for submitting claims to private insurance.)

Organization Id 8117 Organization Name MERCYONE WATERLOO MED CENTER Address 1 3421 W 9TH ST

Address 2 _____ City WATERLOO State IA Zip Code 50702-

SAMPLE INFORMATION (Check appropriate sample type and complete requested information. Only one sample per form.)

Date Collected ___/___/___ Time Collected (24 hr. clock) ___:___ Clinical Diagnosis _____ Date of Onset ___/___/___

Sample Type

☐ CSF ☐ NP wash/aspirate ☐ Tear strip ☐ Vaginal swab ☐ BAL ☐ Lesion swab ☐ Ocular swab ☐ Throat swab ☐ Other: _____ ☐ Buccal swab (Oral swab) ☐ Nasal swab ☐ Rectal swab ☐ Tracheal aspirate ☐ Cervical swab ☐ Nasal wash/aspirate ☐ Sputum ☐ Urethral swab ☐ Combined NP/throat swabs ☐ Nasopharyngeal (NP) swab ☐ Stool ☐ Urine

TEST(S) REQUESTED

PCR

☐ *Bordetella pertussis*
☐ *Chlamydia pneumoniae*
☐ Enterovirus (CSF)
☐ *Legionella pneumophila*
☐ Mumps (Buccal swab)
☐ *Mycoplasma pneumoniae*
☐ Norovirus (Stool)
☐ Herpes Simplex Virus (Not Typed) (CSF or Ocular Swab)
☐ Herpes Simplex Virus Types 1, 2 and Varicella Zoster Virus (VZV) (Lesion Swab)
☐ Other: _____

NAAT

☐ *Chlamydia trachomatis* / *Neisseria gonorrhoeae* (Cervical swab, Rectal swab, Throat swab, Urethral swab, Urine, Vaginal swab)

CV 102021

FACILITIES, PLACE YOUR ELECTRONIC INTERFACE LABEL HERE

FOR STATE HYGIENIC LAB USE ONLY