

Fields with \* and red highlighting are required for testing.



**DHEC 1335 Submission Form**  
 DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL  
 Public Health Laboratory  
 8231 Parklane Road Columbia, SC 29223  
 (803) 896-0800

CLIA#42D0658606

**ALIGN BARCODE LABEL  
 TO TOP OF BOX**

<b>Patient's Name (Last)*</b>		<b>(First)*</b>	<b>(MI)</b>	<b>Sex*</b>	<b>Ethnicity*</b>	<b>Race*</b>	<b>Date of Birth*</b>																												
<b>Address*</b>			<b>City*</b>	<b>State*</b>	<b>Zip Code*</b>	<b>County of Residence*</b>																													
<b>Phone Number</b>		<b>Country of Birth</b>		<b>MCI Number</b>		<b>Local ID</b>	<b>Provider NPI</b>																												
<b>Sender No.</b> 167	<b>Sender Name</b> BEAUFORT MEMORIAL HOSPITAL: LAB H00026			<b>Billing Number</b>	<b>Program No.</b>	<b>Outbreak Number</b>																													
<b>Ordering Physician, Provider and/or Nurse:</b>				<b>Clinical Diagnosis</b>																															
<b>Special Instructions and/or Comments:</b>																																			
<b>Specimen Information</b>				<b>Date of Onset</b>	<b>Agents/Organisms/or Virus Suspected</b>																														
<b>Collection Date:</b>		<b>Collection Time:</b>																																	
		<input type="checkbox"/> AM <input type="checkbox"/> PM																																	
<b>Specimen Type/Source</b>																																			
<input type="checkbox"/> Blood/Serum <input type="checkbox"/> Bronchial wash <input type="checkbox"/> Nasopharyngeal Swab <input type="checkbox"/> Smear (Do not mark for TB) <input type="checkbox"/> Stool specimens		<input type="checkbox"/> Throat swab <input type="checkbox"/> Urine <input type="checkbox"/> Wound pus drainage <input type="checkbox"/> BAL <input type="checkbox"/> Nasal Swab		<input type="checkbox"/> Genital _____ <input type="checkbox"/> Swab _____ <input type="checkbox"/> Tissue/Biopsy _____ <input type="checkbox"/> Other _____		<b>Mycobacteriology Specimens</b> <input type="checkbox"/> Induced sputum <input type="checkbox"/> Spontaneous sputum <input type="checkbox"/> Other _____																													
<b>Symptoms</b>																																			
<input type="checkbox"/> Arthralgia/Myalgia <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Conjunctivitis		<input type="checkbox"/> Diarrhea <input type="checkbox"/> Encephalitis <input type="checkbox"/> Fever		<input type="checkbox"/> Meningitis <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Pleurodynia		<input type="checkbox"/> Rash Type: _____ <input type="checkbox"/> Respiratory <input type="checkbox"/> Other																													
<b>Test Requested</b>																																			
<b>Clinical Microbiology (Bacteriology/Parasitology)</b>																																			
Was culture incubated before transport: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 24 hours <input type="checkbox"/> 48 hours																																			
<input type="checkbox"/> Broth Specimen for Shiga toxin producing E. coli <input type="checkbox"/> CRE/CRPA/CRAB <input type="checkbox"/> Candida ID <input type="checkbox"/> Cryptosporidium Antigen		<input type="checkbox"/> Culture/Isolate for Shiga toxin producing E. coli <input type="checkbox"/> Enteric Culture <input type="checkbox"/> GC Culture and ID		<input type="checkbox"/> Legionella Urine Antigen <input type="checkbox"/> Non-Enteric Culture and ID <input type="checkbox"/> Organism for ID-Aerobic <input type="checkbox"/> Other _____																															
<b>Mycobacteriology</b>																																			
Known TB case? <input type="checkbox"/> Yes <input type="checkbox"/> No		R/O new TB Case? <input type="checkbox"/> Yes <input type="checkbox"/> No		Suspicious hx, s/sx? <input type="checkbox"/> Yes <input type="checkbox"/> No		Current Rx? <input type="checkbox"/> Yes <input type="checkbox"/> No																													
<input type="checkbox"/> Clinical Specimen for ID and Smear <input type="checkbox"/> Isolate for ID <input type="checkbox"/> Blood Culture		<input type="checkbox"/> Drug Susceptibility: <input type="checkbox"/> Clinical Specimen <input type="checkbox"/> Referred Isolate		<input type="checkbox"/> Specimen for Genotyping																															
<b>Virology</b>																																			
<input type="checkbox"/> BioFire Respiratory Panel (Outbreak Only) <input type="checkbox"/> Bordetella (BioFire) <input type="checkbox"/> GI Outbreak (Norovirus RT-PCR and/or Biofire GI panel) <input type="checkbox"/> Influenza RT-PCR In-patient Out-Patient <input type="checkbox"/> QuantiFeron TB-Gold Plus Incubation Start Time:		<input type="checkbox"/> Herpes <input type="checkbox"/> Measles RT-PCR <input type="checkbox"/> Mumps RT-PCR <input type="checkbox"/> Triplex RT-PCR End Time:		COVID RT-PCR First Test?* Employed in healthcare?* Symptomatic (CDC defined)?* Resident in a congregate care facility?*		<table border="1"> <tr> <td>Y</td><td>N</td><td>U</td><td></td><td>Y</td><td>N</td><td>U</td> </tr> <tr> <td></td><td></td><td></td><td>Hospitalized?</td><td></td><td></td><td></td> </tr> <tr> <td></td><td></td><td></td><td>ICU?</td><td></td><td></td><td></td> </tr> <tr> <td></td><td></td><td></td><td>Pregnant?*</td><td></td><td></td><td></td> </tr> </table>		Y	N	U		Y	N	U				Hospitalized?							ICU?							Pregnant?*			
Y	N	U		Y	N	U																													
			Hospitalized?																																
			ICU?																																
			Pregnant?*																																
<b>Special Pathogens</b>																																			
<b>Rule-out Testing</b>		<b>Molecular Testing for Viral Pathogens</b>			<b>Serological Testing</b>																														
<input type="checkbox"/> Bacterial Isolate <input type="checkbox"/> Clinical Specimen Suspect Agent: _____		<input type="checkbox"/> Avian Influenza <input type="checkbox"/> Ebola <input type="checkbox"/> MERS <input type="checkbox"/> Other			<input type="checkbox"/> BMAT <input type="checkbox"/> Malaria																														

DHEC 1335 OE

