Anchorage
Alaska State Public Health Laboratory
PO Box 196093
Anchorage, AK 99507
Phone: (907) 334-2100
HIPAA Compliant Fax: (907) 334-2161

Anchorage Lab Request Form *v05/08/15*

This Space is for Lab Use Only

Patient Information: Preprinted Labels are Recommended

Identifiers on the specimen itself should match the Lab Request exactly.
At a minimum, the specimen should be labeled with:
The patient's first and last name OR unique ID
The patient's date of birth (DOB) OR Medical Record #

☐ Non-Human Sample

Unique Patient ID (Chart #, Prison #): **Collection Date** **Collection Time**

Last Name: **First Name:** MI:

DOB (MM/DD/YYYY): **Gender:** Race:

DOD (Date of Death): City/Village:

Medicare #: Medicaid #:

Chlamydia, Gonorrhea & Trichomonas (NAAT)

☐ Chlamydia & Gonorrhea ☐ Trichomonas, female only ($25 fee)

Specimen Source:
☐ Urine ☐ Urethral ☐ Rectal
☐ Endocervical ☐ Oropharyngeal ☐ Vaginal

Syphilis

Specimen Source: Serum

☐ Syphilis Screen (RPR) with Confirmation (FTA-ABS) if Positive ☐ Syphilis Contact Investigation

Mycobacteriology (TB)

Specimen Source:

☐ Culture/AFB Smear for Mycobacteria (Sensitivities performed on positive TB Only)
☐ AFB Smear Only
☐ Contacted TB Control for TB PCR (907-269-8000)

Parasitology

Specimen Source:

☐ Ova & Parasite Exam ☐ Blood Parasites
☐ *Giardia/Cryptosporidium* by DFA ☐ Pinworm Exam
☐ Ectoparasites
☐ Acid Fast Stain for *Isospora, Cyclospora*, and *Cryptosporidium* Oocysts

Chemistry

☐ Toxic Alcohols and Glycols (Source: whole blood - Gray Top preferred No SST)
☐ Blood Lead (Pb) (Indicate Source: Capillary or venous blood)
☐ Drugs of Abuse Panel (Source: Urine)

Other: **Source:**

****Only approved submitters can request Chemistry testing****

Submitter Information

Ordering Clinician: Physician UPIN:

Facility Name: (Hospital/Clinic/Corrections, etc.) HIPAA Compliant Fax #:

Mailing Address: Phone Number:

City: **State:** **Zip:**

ICD9/ICD10 Diagnosis Codes: Special Project Code:

Bacteriology

Specimen Source:

☐ Enteric Stool Culture (*Salmonella, Shigella, Campylobacter, Escherichia coli* O157)

Additional organisms: ☐ *Vibrio* ☐ *Yersinia* ☐ *Aeromonas/Pleisiomonas*

☐ Enteric confirmation testing. **Organism:** was detected using the following culture independent method: Please attach instrument report.

☐ PFGE and Serotyping
☐ *Campylobacter* ☐ *E. coli* O157 ☐ *Salmonella* ☐ *Shigella*
☐ *Listeria monocytogenes* ☐ *Vibrio parahaemolyticus*

☐ Reference Isolate **Organism suspected:**
☐ Aerobic Bacterial Culture ID
☐ Anaerobic Bacterial Culture ID
☐ Diphtheria Culture
☐ *Neisseria gonorrhoeae* Culture
☐ Culture/Serotyping:(circle) *Neisseria meningitidis* or *Haemophilus influenzae*

Pertussis

Specimen Source: Nasopharyngeal (NP) Swab
Swab must be Dacron or Polyester
☐ Pertussis PCR

Pertussis PCR testing is not recommended for patients on antibiotics for ≥ to 5 days due to potential false negative results.

Botulism

☐ Contacted Epidemiology prior to requesting Botulism testing (907-269-8000)
☐ Contacted Laboratory prior to requesting shipping specimen (907-334-2100)
Date & Time HBAT administered:

Specimen Source:
☐ Pre-Antitoxin Serum ☐ Stool ☐ Gastric/Vomit
☐ Other/Food

Special Pathogens/Biological/Chemical Terrorism Agents

☐ Contacted laboratory prior to requesting testing (1-855-222-9918)

Suspected Agent:

Specimen Source:

If the desired test is not on this form, please review the Fairbanks Public Health Lab Request Form