New Jersey Department of Health
Public Health and Environmental Laboratories

3 Schwarzkopf Drive, Ewing, NJ 08628
https://www.nj.gov/health/phel/

State Lab ID No.

Note: Shaded boxes are for official use only

REQUEST FOR BACTERIAL CULTURE OR PARASITE IDENTIFICATION

ENTER ALL INFORMATION LEGIBLY AND COMPLETELY TO AVOID PROCESSING DELAYS!

Patient Information

Patient Name (First, Last, MI) ***(Must exactly match the name on the specimen)***

Sex for Clinical Purposes ☐ Male ☐ Female ☐ Unknown

Date of Birth

CDRSS Number

Outbreak # E-

Patient Address **Line 2**

City **State** **Zip Code** **Telephone #**

Ethnicity (Select One)

Race (Select One)

Sexual Orientation (Select One)

Gender Identity (Select One)

Pregnancy Status ☐ Pregnant ☐ Not Pregnant ☐ Unknown ☐ Not Applicable

Travel Information
History of recent international travel? ☐ Yes ☐ No ☐ Unknown
Where (countries): _____
Dates of Travel: _____ to _____

Hospitalization Status ☐ Inpatient ☐ Emergency Department ☐ Outpatient ☐ Unknown

ICU ☐ Yes ☐ No ☐ Unknown

Admission Date _____

Symptom Onset Date

Pertinent Clinical Information (brief history, clinical findings, relevant lab data. Attach documents if needed)

Relevant Treatment: Date:

Relevant Immunizations: (Attach documents if needed) _____ Date: _____

Submitter Information

Submitting Facility/Laboratory Information

Facility Name

Submitter Address **Line 2**

City **State** **Zip Code**

Submitter Contact Name *(First, Last, MI)*

Contact Telephone # **Contact Fax #**

Email Address **Patient ID #**

Requesting Physician Information

Physician First Name **Physician Last Name**

Physician Address **Line 2**

City **State** **Zip Code**

Contact Name *(First, Last, MI)*

Contact Telephone No. **Contact Fax #**

Email Address **Patient ID #**

Specimen Information

Specimen ID _____ **Collection Date:** _____ **Time**: _____ AM ☐ PM ☐

NJDOH TEST CODE

Material Submitted ☐ Isolate ☐ Original Material ☐ Slide ☐ Other: _____

Specimen Source Type ☐ Blood ☐ Stool ☐ Swab ☐ CSF ☐ Aspirate ☐ Urine ☐ Sputum ☐ Other: _____

Specimen Source Site (arm, nasopharynx, joint, etc.)

Suspected Organism(s)

Previous Laboratory Tests Conducted/Results (Attach Copy of Test Results)

DATE/TIME RECEIVED

Test(s) Requested:

Serotyping/Serogrouping:
- ☐ *H. influenzae*
- ☐ *N. meningitidis*
- ☐ Other*: _____

Enterics:
- ☐ Salmonella
- ☐ Yersinia
- ☐ Shigella
- ☐ Vibrio
- ☐ Listeria
- ☐ Shiga Toxin Producing E. *coli*
- ☐ Other*: _____

Parasitology:
- ☐ Blood Smear – Morphologic ID:
  - ☐ Malaria ☐ Babesia
- ☐ Other*: _____

Antimicrobial Resistance:
- ☐ AR Surveillance
- ☐ *C. auris**
- ☐ Other*: _____

Legionella:
- ☐ PCR
- ☐ Culture

☐ **Reference Laboratory***: Specify Laboratory and Test _____

** Specimen submission requires prior approval (See Instructions)*

INSTRUCTIONS FOR COMPLETING THE "REQUEST FOR BACTERIAL CULTURE OR PARASITE IDENTIFICATION" FORM

Please direct clinical or epidemiological questions to the NJ Communicable Disease Service and specimen submission or laboratory questions to the NJ Public Health Laboratory.

For All Test Requests:

1. Complete a separate form for each specimen.
2. Provide all information requested on the form.
3. Specimens should be labeled with two (2) identifiers (e.g., patient name, date of birth, other unique patient ID).
4. Should you need additional space, please submit a separate sheet of paper that includes patient name and date of birth.
5. Specimen and BACT-109 identifiers must match EXACTLY.
6. Specimens may be rejected, and testing will be delayed if information is missing, incomplete, or inaccurate.
7. Please include a copy of any available laboratory test results

For Bacterial Isolates:

- Submit fresh (24-48 hour) cultures on SBA, TSA or Chocolate agar slants.
- Ship at room temperature.
- Do not submit plates.
- Ship isolates as soon as they are identified and do not batch.

For all parasites other than Malaria and Babesia, please contact the NJ Public Health Laboratory for approval at (609) 530-8554.

For Legionella PCR:

- Collect specimens prior to antibiotic treatment, if possible.
- Refrigerate (2-8°C) specimens after collection and freeze (-20°C or lower) as soon as possible within 96 hours. Ship frozen specimens to NJDOH within 7 days.
- Minimum Volume Required: 0.2mL; 0.5 mL preferred.
    - Include sufficient dry ice or super cold packs to maintain the required temperature through transit.
- Isolates should be shipped refrigerated or at room temperature.

Shiga Toxin Producing *E. coli* (STEC):

- Submit fresh 24-hour STEC broths.
- Ship at room temperature.
- Ship these broths as soon as they are identified.
- Broths should be stored at 4°C prior to submission.

Parasitology:

- For blood parasites, submit fresh EDTA whole blood, stained and unstained smears.
- Ship at room temperature.
- Blood and slides should be stored at room temperature prior to submission. Indicate any
- preliminary observations and provide travel history.

***Tests Requiring Prior Approval:**

Please contact the Communicable Disease Service at (609) 826-5964 for tests requiring prior approval:

- *C. auris* testing.
- Any test designated on the Bact-109 as "other".
- Any test that will be sent through the state laboratory to a reference laboratory (e.g., CDC, Wadsworth) with the exception of parasites.

Package and Ship all specimens according to USDOT Hazardous Materials Transport regulations 49 CFR parts 171-178. Package and ship all Category A infectious substances following USDOT 49 CFR 173.196. Package and ship all Category B infectious substances following the USDOT 49 CFR 173.199. Overnight deliveries are accepted Tuesday through Friday 8:30 am to 3:30 pm; except state holidays. Ground deliveries are accepted Monday through Friday 8:30 am to 3:30 pm; except state holidays. For further questions regarding packaging and shipping please contact PHEL Receiving at (609) 530-8387. Please find link to the state courier service here: https://www.nj.gov/health/phel/.

Ground deliveries should be made to:

New Jersey Public Health and Environmental Laboratories
Specimen Receiving Unit
3 Schwarzkopf Drive
Ewing, NJ 08628

INSTRUCTIONS FOR COMPLETING THE "REQUEST FOR BACTERIAL CULTURE OR PARASITE IDENTIFICATION" FORM

If completing a printed copy of this form, please use the following legend to fill in the "Patient Information" section. Please write the option exactly as it appears below:

Sexual Orientation

Lesbian
Gay
Straight
Bisexual
Unknown
Decline to answer
Something Else

Gender Identity

Male
Female
Transgender Male (TM)/Female to Male
Transgender Female (TF)/Male to Female
Genderqueer/Non-Binary
Decline to Answer
Other

Ethnicity

Hispanic or Latino
Not Hispanic
Unknown

Race

American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander White
Other Race