Washington State Department of Health
Public Health Laboratories

State of Washington Department of Health
PUBLIC HEALTH LABORATORIES
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ARLABnetwork

Reset Patient Information

Reset All Fields

PATIENT INFORMATION

LAST NAME

FIRST NAME | MIDDLE INITIAL | DATE OF BIRTH (DOB)

MEDICAL RECORD #/ PATIENT ID | PHL ISOLATE OR SPECIMEN ID

GENDER
☐ MALE ☐ MALE-TO-FEMALE TRANSGENDER ☐ INTERSEX ☐ UNKNOWN
☐ FEMALE ☐ FEMALE-TO-MALE TRANSGENDER ☐ UNSPECIFIED

STREET ADDRESS | CITY

STATE/TERRITORY | ZIP CODE | COUNTY/BOROUGH /VILLAGE

SUBMITTER INFORMATION

SUBMITTING FACILITY NAME

NAME AND TITLE OF PERSON ORDERING TEST

PHONE NUMBER | CONFIDENTIAL/SECURE FAX NUMBER

FACILITY ADDRESS | CITY

STATE/TERRITORY | ZIP CODE | COUNTY/BOROUGH/VILLAGE

SAMPLE COLLECTION FACILITY INFORMATION

Complete this section if the submitting facility differs from the healthcare facility where the patient was located at the time of collection (i.e. the sample collection facility).

COLLECTION FACILITY NAME

NAME AND TITLE OF COLLECTION FACILITY POINT OF CONTACT

PHONE NUMBER | CONFIDENTIAL/SECURE FAX NUMBER

FACILITY ADDRESS | CITY

STATE/TERRITORY | ZIP CODE | COUNTY/BOROUGH/VILLAGE

PUBLIC HEALTH DEPARTMENT INFORMATION

Only complete this section for colonization screening. All screenings must be approved by the HAI/AR Coordinator or Public Health official.

NAME AND TITLE OF APPROVING PUBLIC HEALTH

PHONE NUMBER | CONFIDENTIAL/SECURE FAX NUMBER

JURISDICTION | **Is this screening approved by Public Health?** ☐ YES | DATE APPROVED

TEST REQUESTED

Please select **ONE** test option below.

ISOLATE TESTING:
- ☐ **CRE (Carbapenem-resistant Enterobacteriaceae) testing**
  - ☐ **Expanded Antimicrobial Susceptibility Testing (ExAST)** Pre-approval required
- ☐ **CRPA (Carbapenem-resistant *Pseudomonas aeruginosa*) testing**
- ☐ **CRAB (Carbapenem-resistant *Acinetobacter baumannii*) testing**
- ☐ ***Candida* species identification and susceptibility testing**

COLONIZATION SCREENING: Pre-approval required
- ☐ **CPO (Carbapenemase producing organism) colonization screening**
- ☐ ***Candida auris* colonization screening**
- ☐ **Targeted surveillance screening**

SPECIMEN INFORMATION

DATE COLLECTED (mm/dd/yyyy) | TIME COLLECTED ☐ AM ☐ PM | DATE SENT TO ARLN

SPECIMEN TYPE: **Please only select one** ☐ Isolate ☐ Swab ☐ Other (specify)_____

SPECIMEN SOURCE: **Please select ONE source option below.**

☐ AXILLA/GROIN
☐ BLOOD
☐ BRONCHIAL WASH
☐ FLUID (site)_____
☐ RECTAL
☐ SKIN(specify)_____
☐ SPUTUM
☐ STOOL
☐ TISSUE (specify)_____
☐ UNKNOWN/OTHER (specify)_____
☐ URINE
☐ WOUND (site)_____

Have submissions from this patient been submitted previously? ☐ YES ☐ NO ☐ UNKNOWN

PREVIOUS RESULTS: **For isolate testing, please attach your identification & susceptibility results for this isolate. Please also complete the section below with those results. For colonization screening, information on the index isolate can be included below.**

GENUS & SPECIES

CARBAPENEMASE GENE(S) PRODUCED (If applicable, CRE, CRPA, CRAB only)
☐ KPC ☐ VIM ☐ OXA-48 ☐ IMP ☐ NDM ☐ OTHER (specify)_____

CARBAPENEM SUSCEPTIBILITY **CRE, CPRA, CRAB only**	IMIPENEM	MEROPENEM	ERTAPENEM	DORIPENEM

GENERAL SHIPPING INSTRUCTIONS

- **Please print legibly and complete all fields.**
- Each specimen must be clearly marked with **two unique patient identifiers that exactly match this form.**
- Please attach a copy of your species identification and sensitivity results. **Testing may be delayed if submitted without.**
- All shipped specimens must meet Department of Transportation and US Postal Service regulations. It is the shipper's responsibility to ensure all regulations are met.
- Ship to: **AR LAB NETWORK**
  WASHINGTON STATE DEPARTMENT OF HEALTH
  1610 NE 150TH STREET
  SHORELINE, WA 98155