

Enteric Disease Test Request Form

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|--|--|
| Patient Name: _____ | |
| Patient ID Number: _____ | |
| Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| Zip Code: _____ | |

| |
|--|
| Collection Date: _____ |
| Date of Birth: _____ |
| Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian |
| <input type="checkbox"/> American Indian <input type="checkbox"/> Alaskan Native |
| <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other |

ONSET: <6 hours SYMPTOMS: Watery diarrhea
 6-18 hours Bloody diarrhea
 18-72 hours Fever
 >3 days Vomiting

Has patient received antibiotic therapy? Yes No

Antibiotic: _____

Is this submission associated with an outbreak? Yes No

Outbreak #: _____

Is this submission for test of cure? Yes No

Which organism? _____

ALL SAMPLE CONTAINERS MUST BE CLEARLY MARKED WITH PATIENT IDENTIFICATION!

BACTERIAL ENTERITIS:

Submit stool in C&S "PARA-PAK" or Cary-Blair Medium

- Enteric Screen
 - Culture for *Salmonella*
 - Culture for *Shigella*
 - Culture for *Campylobacter*
 - Culture for Shiga toxin-producing *Escherichia coli* (Including O157:H7)
- Culture for *Yersinia*
- Culture for *Aeromonas* or *Plesiomonas*
- Culture for *Vibrio*
- Other: _____

VIRAL ENTERITIS:

Submit stool (without preservative) or vomitus

- Norovirus

Send report to:

Send copy to:

Facility: _____

Facility: _____

Attention: _____

Attention: _____

Address: _____

Address: _____

City: _____

City: _____

State: _____ Zip: _____

State: _____ Zip: _____

Telephone: _____

Telephone: _____