

Alabama Department of Public Health (ADPH)
Bureau of Clinical Laboratories (BCL)
Requisition Form for Laboratory Testing

Complete a separate form for each test requested. Ensure all requested information is complete and correct before submission.

Patient Information				Healthcare Provider Information			
Patient ID Number/MRN		Specimen Collection Date / /		Facility Name			
Patient First & Last Name		Date of Birth (mm/dd/yyyy) / /		Physician/Requestor First & Last Name		NPI#	
Specimen Source	Race (mark all that apply) ☐ American Indian/ Alaska Native ☐ Asian ☐ Black/African-American ☐ Native Hawaiian/ Pacific Islander ☐ White/Caucasian ☐ Unknown	Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown		Street Address			
Specimen Type		Sex ☐ Male ☐ Female ☐ Other (Specify) _____		City			
Hospitalized ☐ No ☐ Unknown ☐ Yes		Pregnant? ☐ Yes ☐ No		Phone Number		Fax Number	
Date of Onset / /				Arrival Temperature: _____ °C Initials: _____ Time: _____			
Patient Street Address				LABORATORY USE ONLY			
City		State					Zip
Patient SSN		Patient Phone Number					
Insurance Information (Include Copy of Insurance Card)							
Bill To	☐ Patient's Insurance	☐ Patient	☐ Ordering Facility	☐ ADPH Program _____			
Insurance Carrier	Policy Holder's First & Last Name		ID Number	Group Number			
☐ BC/BS ☐ United Healthcare ☐ Medicaid ☐ Medicare ☐ No Insurance ☐ Other (Specify) _____	Policy Holder's DOB (mm/dd/yyyy)		Policy Holder's Mailing Address		Relationship of Insured to Patient (Self, Spouse, Child, etc.)		
	Diagnosis Code(s) ICD-10	Code 1	Code 2	Code 3			
Test Requested				Additional Information That Might Be Required			
☐ AFB Smear & Culture ☐ AFB Isolate for Identification ☐ Xpert/RIF (PCR) TB Specimen: Any source EXCEPT blood, bone marrow or gastric ☐ CT/GC/TV – Collected by patient? ☐ Yes / ☐ No ☐ Syphilis – History of treatment? ☐ Yes / ☐ No ☐ HIV Screening ☐ HIV Viral Load ☐ Blood Lead ☐ Capillary ☐ Venous Follow-up? ☐ Yes / ☐ No ☐ Lymphocyte Subset (CD4) ☐ Lymphocyte Subset (CD4) % ☐ Hepatitis A IgM ☐ Hepatitis C Antibody ☐ Hepatitis C Viral Load ☐ Hepatitis B Surface Antibody ☐ Hepatitis B Surface Antigen ☐ Post Vaccine Employee? ☐ Yes / ☐ No Needle Stick? ☐ Yes / ☐ No ☐ CBC with differential ☐ CBC without differential Chemistry Panels (Only one form required per Chemistry request) ☐ Comprehensive Metabolic ☐ Hepatic Function ☐ Electrolytes ☐ add Glucose ☐ add Phosphorous ☐ Lipid ☐ Basic Metabolic ☐ Renal Function ☐ Thyroid ☐ add Glucose ☐ add Phosphorous ☐ Chemistry Analyte(s): _____ ☐ Mycology ☐ Influenza – Rapid test result: _____ ☐ Arboviral Testing: _____ ☐ Microbiology – Reference / Gram Stain: _____ ☐ <i>Salmonella</i> / <i>Shigella</i> ☐ <i>Campylobacter</i> ☐ <i>Vibrio</i> ☐ <i>E. coli</i> ☐ Enteric Fecal Screen ☐ Microbiology – PCR: _____ ☐ Parasitology ☐ Urine Culture – Symptomatic / Post Treatment / Other: _____ ☐ COVID-19 ☐ Other Test: _____				Suspected Agent: _____			
				Outbreak/Case ID: _____			
				Recent Travel? ☐ Yes / ☐ No Dates: ____/____/____ – ____/____/____ Where? _____			
				Recent Vaccine? ☐ Yes / ☐ No Date: ____/____/____ What type? _____			
				Animal Exposure? ☐ Yes / ☐ No Exposure Date: ____/____/____			
Special Instructions							