Bureau of Clinical Laboratories
204 Legends Court
Prattville, AL 36066
334-290-6130

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

Mobile Division Laboratory
757 Museum Drive
Mobile, AL 36608
251-344-6049

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

Patient Information

Patient ID Number/MRN	Specimen Collection Date
	/ /
Patient First & Last Name	**Date of Birth (mm/dd/yyyy)**
	/ /

Specimen Source

Specimen Type

Hospitalized
☐ No ☐ Unknown
☐ Yes

Date of Onset
/ /

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

Sex
☐ Male ☐ Female
☐ Other (Specify) _____
Pregnant? ☐ Unknown ☐ Yes ☐ No

Patient Street Address

City	State	Zip

Patient SSN	Patient Phone Number

Healthcare Provider Information

Facility Name

Physician/Requestor First & Last Name	NPI#

Street Address

City	State	Zip

Phone Number	Fax Number

Arrival Temperature: _____°C | **Initials**: _____ | **Time**: _____

LABORATORY USE ONLY

Insurance Information (Include Copy of Insurance Card)

Bill To ☐ Patient's Insurance ☐ Patient ☐ Ordering Facility ☐ ADPH Program _____

Insurance Carrier
☐ BC/BS
☐ United Healthcare
☐ Medicaid
☐ Medicare
☐ No Insurance
☐ Other (Specify) _____

Policy Holder's First & Last Name	ID Number	Group Number

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

☐ AFB Smear & Culture ☐ AFB Isolate for Identification ☐ Xpert/RIF (PCR)
TB Specimen: A*ny 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: _____
☐ *Salmonella / Shigella* ☐ *Campylobacter* ☐ *Vibrio* ☐ *E. coli*
☐ Enteric Fecal Screen
☐ Microbiology – PCR: _____
☐ Parasitology
☐ Urine Culture – Symptomatic / Post Treatment / Other: _____
☐ COVID-19
☐ Other Test: _____

Additional Information That Might Be Required

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

_____
_____
_____
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