MISSISSIPPI STATE DEPARTMENT OF HEALTH

Mississippi Public Health Laboratory
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CLIA #: 25D1096223

Clinical Select Agent Rule-Out Submission Requisition

Please make sure the information on the form is legible and complete.

SUBMITTER INFORMATION ***PATIENT INFORMATION***

Patient ID Number		**PATIENT NAME (Last)**	**(First)**	**MI**	**Suffix**

Submitting Facility	**County of Residence**	**Date of Birth**

Street Address	**Street Address**

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

Specimen Type and Date of Collection

○ Primary ○ Isolate

Date of Collection: _____

Specimen Source

☐ Blood ☐ CSF ☐ Urine ☐ Nasopharyngeal Stool
☐ Tissue (site)_____ ☐ Wound (site)_____
☐ Sputum ☐ Other: _____

Test Requested:

- ☐ *Bacillus anthracis*
- ☐ *Brucella* species
- ☐ *Burkholderia mallei*
- ☐ *Burkholderia pseudomallei*
- ☐ *Bacillus cereus*, biovar *anthracis*
- ☐ *Coxiella burnetii*
- ☐ *Clostridium botulinum*
- ☐ *Francisella tularensis*
- ☐ *Yersinia pestis*
- ☐ Other: _____

Race

- ☐ American Indian
- ☐ Asian
- ☐ Black
- ☐ Pacific Islander
- ☐ White
- ☐ Other

Sex

- ○ Male
- ○ Female

Ethnicity

- ○ Hispanic
- ○ Non-Hispanic

Clinical and/or Epidemiological Information

Any Associated Illness:
Foreign or Domestic Travel? YES NO **Where?** _____ **When?** _____

Submitting Facility Required Test Results

Gram stain result and characteristics: (size and appearance):

Media	**Growth Description**			
	24h	**48h**	**72h**	**Example descriptions:**
BAP				No growth, round, irregular, flat, convex, raised, small, large, mucoid, rough, pinpoint, swarming, ground glass, waxy, grey, white, fried egg, bulls-eye, hemolytic (β, α, γ) lactose fermentation
CHOC				
MAC				
Other				

Rule-Out Tests					
	POS	**NEG**	**INDETERMINANT**	**NOT PERFORMED**	**Additional Rule-out Tests**
Catalase	☐	☐	☐	☐	
Oxidase	☐	☐	☐	☐	
Indole	☐	☐	☐	☐	
Urease	☐	☐	☐	☐	
Hemolysis	☐	☐	☐	☐	
Satellite	☐	☐	☐	☐	
Beta-lactamase	☐	☐	☐	☐	
Motility 25°C	☐	☐	☐	☐	
Motility 35°C	☐	☐	☐	☐	
TSI Reaction:					

Susceptibility Tests					
	ZONE	**NO ZONE**	**INDETERMINANT**	**NOT PERFORMED**	**Additional Tests Performed**
Amoxicillin clavulanate					
Colistin					
Doxycycline					
Penicillin					
Polymyxin					
Rifampin					

Attach a copy of any relevant testing results not documented above.

Mississippi State Department of Health
Form Instructions

CLINICAL SELECT AGENT RULE-OUT SUBMISSION REQUISITION

FORM NUMBER **F-1251**

REVISION DATE **June 18, 2021**

RETENTION PERIOD **The MSDH Laboratory will retain the original form in accordance with Clinical Laboratory Improvement Amendments (CLIA) regulations.**

PURPOSE

To collect submitter information, patient demographics and specimen information for specimens submitted from clinical laboratories for select agent rule-out testing.

INSTRUCTIONS

Submitter Information- Left hand side of requisition

Record all requested information.
Patient ID Number: Enter the submitter's patient identification number.
Submitter Name: Enter the submitting facility's full name.
Street Address: Enter the submitting facility's street address.
City: Enter the submitting facility's city
State: Enter the submitting facility's state
Zip: Enter the submitting facility's zip code
Phone Number: Enter the submitting facility's phone number.
Contact Name: Enter the name of the submitting facility's contact if applicable.
Contact: Enter the phone number of the submitting facility's contact if applicable

Patient Information – Right hand of requisition

Patient Name- Enter the patient's LAST NAME, FIRST NAME, MIDDLE INITIAL and SUFFIX in sequence. The spelling of the patient's name on the laboratory slip and the specimen container/tube must be identical. **Name listed must be legal name; DO NOT use nicknames**.
County of Residence- Enter the county where the patient currently resides (Hinds, Rankin, etc).
Date of Birth- Provide in MM/DD/YY format.
Address - Enter the complete address where the patient currently resides.
City - Enter the name of the city in which the patient resides.
State - Enter the state in which the patient resides.
Zip Code - Enter the Zip Code of the patient's address.
Phone Number – Enter patient's telephone number including area code.
Specimen Type and Date of Collection: Mark primary or isolate for the type specimen being submitted. Provide the Date of collection in MM/DD/YY format.
Specimen Source: Select the source of the specimen. If other, write in the source.
Test Requested: Check the box by the appropriate test requested. If other, write in the requested test.
Race – Check the box associated with the patient's race.
Ethnicity- Check the appropriate box.
Gender- Check the appropriate box (male or female)

Clinical and/or Epidemiological Information:

Any associated illness: List associated illness.
Any Foreign or Domestic Travel: Select yes or no. If yes, list the location of date of travel.

Required Submitter Test Results: Provide all applicable information requested. Check the applicable information boxes or enter the information in the space provided. Mark NA if the requested information is not applicable. Attach a copy of any relevant testing results not documented on the requisition.

OFFICE MECHANICS AND FILING

This form must accompany each patient for whom specimens are submitted to the MSDH Laboratory. A copy should be retained by the submitter as documentation of submission. Test results will be reported via computer generated report and forwarded to the submitter.