Bacteriologic Examination History

Clinical Bacteriology Laboratory
Wadsworth Center
New York State Department of Health
Empire State Plaza
P O Box 509, Albany, New York 12201-0509

NYS Accession Number and Date Received

Patient

Last Name	First Name	MI	Sex	DOB _____/_____/_____ MM DD YYYY
Street Address	**City**	**Zip Code**		**County of Residence**

Specimen

Specimen is: ☐ Isolate ☐ Primary patient material ☐ Primary environmental material ☐ Food ☐ Other

Source	Date Collected _____/_____/_____ MM DD YYYY	Submitter's Lab Number	NYS DOH Outbreak Number (if applicable)

Submitter

Submitter Name and Address **Laboratory PFI** _____

Contact Person _____

Telephone _____ **Fax** _____

Test

Suspected organism :

_____

Identification / confirmation of

☐ Aerobe ☐ Anaerobe ☐ Other
☐ *Pertussis*
☐ *Legionella*

Serotyping / serogrouping of

☐ *Salmonella*
☐ *E. coli* O157:H7
☐ *H. influenzae*
☐ *N. meningitidis*
☐ Other _____

If you participate in the Emerging Infections Program, Is this an EIP organism from an EIP county?

☐ Yes ☐ No ☐ Unknown (see reverse side)

Other Tests

*☐ Cluster or Outbreak study
*☐ *Cl. botulinum* culture and/or toxin
*☐ Food Poisoning [specify organism(s)]

*☐ *Bacillus anthracis*
*☐ *Brucella* species
*☐ *Burkholderia mallei*
*☐ *Burkholderia pseudomallei*
*☐ *Francisella tularensis*
*☐ *Leptospira s*pecies
*☐ *Yersinia pestis*

***CALL THE LABORATORY AT 518-474-4177 FOR INSTRUCTIONS FOR THESE TESTS.**

Findings

Submitting Facility Findings

Gram Reaction: Morphology:

☐positive ☐bacilli
☐negative ☐coccobacilli
☐variable ☐cocci

Unusual Characteristics:

Does this organism show unusual antibiotic resistance?

☐No ☐Yes: To which antibiotics?

Name of patient's healthcare provider:

_____

Telephone number _____

Diagnosis: _____

Date of onset _____/_____/_____ MM DD YYYY

Antibiotic given: _____

Date started _____/_____/_____ MM DD YYYY

Exposure/Travel History

☐ Contact of a known case
☐ Travel
☐ Exposure to animal

Guide for Submitting Specimens or Isolates for Bacteriological Examination
PLEASE TYPE OR WRITE CLEARLY AND LEGIBLY

Patient Information

DOB: Date of Birth. If date of birth is not available, give the age of the patient.

Address: Print the **patient's address**. Do not put the address of the hospital/laboratory/ physician in this space.

County of Residence: Provide the county where the patient currently resides. Do NOT use the county where the laboratory or physician is located.

Specimen Information

Specimen is: Tell us what kind of material you are sending.

Source: Give the source of the specimen or isolate, such as blood, stool, wound.

Date Collected: Give the date the specimen was collected from the patient or other source. Do not give the date it was sent to the Wadsworth Center.

Submitter's Lab Number: Give your identification number for the specimen/isolate.

NYSDOH Outbreak Number: If the specimen/isolate is part of an outbreak or cluster, give the number assigned to the outbreak by the investigating health care agency (if any).

Submitting Facility Information

Submitter Name and Address: Give the complete name and address of the submitting HOSPITAL, LABORATORY, PHYSICIAN, INSTITUTION, or STATE AGENCY. Please write clearly, or use a stamp or pre-printed label.

PFI: Write the PFI number assigned to your laboratory by the New York State Proficiency Test (PT) Program. This number appears as the first group of numbers (4 digits) on the first line of the address label on any mailings you receive from the PT Program.

Contact: Give the name and telephone number of the person to contact at the submitting facility if additional information about the specimen/isolate is needed.

Test

Test Requested: Give the name or the suspected name of the organism. Check or specify the specific test(s) to be performed by the Wadsworth Center.

If your facility is a participant in the Emerging Infections Program (EIP): If the suspected organism is on the list below, and the patient resides in one of the counties listed below, check Yes. If not, check No. If you do not have this information, check Unknown. IF YOU ARE NOT A PARTICIPATING FACILITY, IT IS NOT NECESSARY TO REPLY TO THIS QUESTION.

EIP COUNTIES:

Albany	Niagara*
Ontario	Orleans
Columbia	Rensselaer
Erie*	Saratoga
Genesee	Schenectady
Greene	Schoharie
Livingston	Wayne
Monroe	Wyoming*
Montgomery	Yates

EIP ORGANISMS INCLUDED:

Campylobacter species	*Shigella* species
E. coli O157:H7	*Streptococcus* Gp. A
Haemophilus influenzae	*Streptococcus* Gp. B
Listeria monocytogenes	*Strep. pneumoniae*
Neisseria meningitidis	*Vibrio* species
Salmonella species	*Yersinia* species

*Submit enteric EIP organisms only.

Findings

Submitting Facility: Give any of your findings that may assist us in processing and identification of this specimen/isolate.

Name of Healthcare provider: Give the name and telephone number of the physician or other provider who initially ordered the test.

Diagnosis, **Antibiotic Therapy**, and **Exposure/Travel:** Give as much information as possible.

When your laboratory findings indicate a reportable communicable disease, promptly report the case to the local health department which serves the area where the patient currently resides, in accordance with Public Health Law 2102. See form DOH-389, "Confidential Case Report."