

**Specimen Type:** Check appropriate specimen and fill in requested information (Only one sample per form).

- Blood
- CSF
- Peritoneal Fluid
- Pleural Fluid
- Synovial fluid  
Source: \_\_\_\_\_
- SSSI (MRSA only)
  - Wound/Tissue/Biopsy
    - Pus
    - Abscess
    - Deep Wound
      - Surgical
    - Furuncle
    - Boil
  - Other: \_\_\_\_\_

PATIENT: \_\_\_\_\_ last first

BIRTH DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ mm dd year      SSN #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_ ZIP: \_\_\_\_

PHONE: (\_\_\_\_) \_\_\_\_ - \_\_\_\_      GENDER:  Female  Male

RACE:  White  Black  Asian  American Indian / Alaskan Native  
 Native Hawaiian / Pacific Islander  Unknown

ETHNICITY:  Hispanic  Non Hispanic  Unknown

PATIENT ID #: \_\_\_\_\_

CLINICIAN: \_\_\_\_\_ CLINICIAN ID #: \_\_\_\_\_  
please print last first

PHONE: (\_\_\_\_) \_\_\_\_ - \_\_\_\_      CLINICIAN'S Signature: \_\_\_\_\_

DATE COLLECTED: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ mm dd year

**Required Information**

**Organism (complete Patient History Part A)**

- MRSA (also complete Patient History Part B)
- VISA / VRSA (also complete Patient History Part B)
- S. pneumoniae
- S. pyogenes
- H. influenzae
- N. meningitidis
- Other, Specify: \_\_\_\_\_

Lab #: \_\_\_\_\_

**Patient Facility (if different from submitter)**

Facility Name: \_\_\_\_\_

Facility City, State: \_\_\_\_\_

**Susceptibility Testing Results**

- Not Done      Done: Method
- Broth Microdilution
    - Manual
    - Automated
  - E-test
  - Disk-diffusion
  - Other: \_\_\_\_\_

**Patient History**

**A. At time of specimen collection:**

- Inpatient?  Yes  No
- ICU / CCU?  Yes  No
- Admit date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ mm dd year

**B. For all MRSA submitted: (to be completed by ICP) (check all that apply)**

- >= 2 days hospitalization
- History of hospitalization within the last year
- History of surgery within the last year
- Dialysis within the last year
- LTCF resident within the last year
- Permanent indwelling catheter
- Percutaneous medical device
- Previous culture positive for MRSA
- Athlete
- Prisoner
- Healthcare worker


*Invasive Disease Reporting /  
Antimicrobial Resistant Surveillance  
Test Request Form*

**University Hygienic Laboratory**  
 102 Oakdale Campus, #101 OH  
 Iowa City, IA 52242-5002  
 Phone #: 319-335-4500  
 Fax #: 319-335-4555  
<http://www.uhi.uiowa.edu>

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

 Enter your facility address  
Results are returned  
to this address