DEPARTMENT OF HEALTH

Submit Sample(s) to:
MN Public Health Laboratory
Infectious Disease Lab
601 Robert St. N
St. Paul, MN 55155

Phone (651) 201-5200
Fax (651) 201-5070
Specimen Receiving (651) 201-4953
CLIA# 24D0651409

MDH Lab Use Only
Condition:
Room Temp
Frozen
Cool Pack
Barcode Sticker

Infectious Disease Laboratory Submission Form

* Required Fields

Submitter

*Submitting Facility: Allina Health Laboratory-Abbott Northweste
*Address: 2800 10th Ave S
Suite 2000
City: Minneapolis State: MN Zip: 554407
Name of Person Filling Out Form:
Phone: (612) 863-4356
Originating Facility:
Ordering Provider:
Project Number if Known:

Patient

*Last Name:
*First Name:
Address:
City: State: Zip:
Patient MRN #: Sex:
*Date of Birth: (mm/dd/yyyy) Ethnicity:
Race:

Specimen

*Submitter Sample ID:
*Date of Collection (mm/dd/yyyy):
Time of Collection (##:##):
AM ☐ PM ☐

Reportable Disease/Referral

Reportable Disease Specimen (Test assigned by MDH)

Source: Site:
CIDT Platform:
Organism 1:
Organism 2:
Organism 3:
Organism 4 / Specifiy Other:

Reportable Disease Isolate (Test assigned by MDH)

Source: Site:
Organism:

Referral Testing at CDC:

CDC Test:

Submitting Laboratory - Specify Any Other Organism/Test Info or Comments:

Test and Epidemiology Information

Virology

Source: Site:
Test Requested:
Date of Symptom Onset:
Vaccination Date:

Serology

Source: Site:
Test Requested:
Date of Symptom Onset:
Previous Result:

Influenza

Source: Site:
Test Requested:
Date of Symptom Onset: Date of Vaccination:
Result/Subtype: Test by Submitter:

Microbiology

Source: Site:
Test Requested:
*Prior MDH Notification #Prior MDH Authorization

Mycobacteria

Source: Site:
Test Requested:
AFB Isolate Media Submitted :
M.TB Complex PCR only Smear Result:
M.TB Complex PCR only Specimen Condition:

Parasitology

Source: Site:
Test Requested:

Mycology

Source: Site:
Test Requested:
Probe: ☐ Blasto ☐ Histo ☐ Cocci

Other

Source: Site:
Test Requested: