FACILITIES, PLACE YOUR PATIENT INFORMATION/ELECTRONIC INTERFACE LABEL HERE OR COMPLETELY FILL OUT INFORMATION BELOW

State Hygienic Laboratory at the University of Iowa

U of I Research Park
2490 Crosspark Road
Coralville, IA 52241-4721
Phone # 319-335-4500 or
800-421-IOWA

Ankeny Laboratory
2220 S. Ankeny Blvd.
Ankeny, IA 50023-9093
Phone # 515-725-1600

Lakeside Laboratory
1838 Highway 86
Milford, IA 51351-7267
Phone # 712-337-3669

http://www.shl.uiowa.edu

Legionella Reference Center Clinical Test Request Form

PATIENT INFORMATION **Sample must have two patient identifiers that match this form.**

Client Reference (Patient ID/MRN/Chart ID) _____ Last Name _____ Legal First Name _____ Middle Name _____

Birth Date (yyyy-mm-dd) _____

Sex ☐ Female ☐ Male ☐ Unknown

Race ☐ White ☐ Black ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ Unknown

Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

PUBLIC HEALTH LABORATORY INFORMATION (Results are reported to this address.)

PHL ORG. ID _____ Organization Name _____ Address 1 _____

Address 2 _____ City _____ State _____ Zip Code _____

BILLING INFORMATION

☒ BILL TO: ID 22742, SHL LEGIONELLA REFERENCE CENTER, UNIVERSITY OF IOWA RESEARCH PK, 2490 CROSSPARK RD, CORALVILLE, IA 52241

SAMPLE AND TEST INFORMATION (Complete collection date and time and select sample type.)

Date Collected (yyyy-mm-dd) _____ Time Collected (24 hr. clock) _____ Sample Type <click here to select> Source _____

☒ Legionella Panel

REQUESTED INFORMATION FOR PUBLIC HEALTH PURPOSES

Clinical Diagnosis: _____ Date of Onset (yyyy-mm-dd): _____

Previous urinary antigen test result: ☐ Positive ☐ Negative

Previous culture-based test result: ☐ Positive ☐ Negative

PCR Performed? ☐ Yes ☐ No

Previous PCR test result: ☐ Positive ☐ Negative PCR manufacturer/method: _____

PCR Target 1 detected name: _____ Cycle Threshold Value 1: _____

PCR Target 2 detected name: _____ Cycle Threshold Value 2: _____

PCR Target 3 detected name: _____ Cycle Threshold Value 3: _____

Resident in a congregate care setting: ☐ Yes ☐ No ☐ Unknown

Hospitalized (inpatient/admitted): ☐ Yes ☐ No

Collection Facility (name of facility where sample was collected): _____

Collection City (city where sample was collected): _____

Name of antibiotics used: _____ Antibiotics Start Date: _____

Submitting PHL Contact Name: _____ Submitting PHL Contact Phone: _____

Submitting PHL Contact Fax: _____ Submitting PHL Contact Email: _____

Submitting Epi Contact Name: _____ Submitting Epi Contact Phone: _____

Submitting Epi Contact Email: _____

For State Hygienic Lab Use Only

Condition Received	Temp.	Thermometer ID
Ambient		
Cold Pack/Refrigerated		**Rec'd by**
Frozen		

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CR 072025