MISSISSIPPI STATE DEPARTMENT OF HEALTH

Mississippi Public Health Laboratory
570 East Woodrow Wilson Jackson, MS 39216
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CLIA #: 25D1096223

CRE, CRPA and CRAB Isolate Submission Requisition

Complete a separate form for each test requested

SUBMITTER INFORMATION ***PATIENT INFORMATION***

Patient ID Number		**PATIENT NAME (Last)**	**First**	**MI**	**Suffix**
Submitter Name		**County of Residence**		**Date of Birth**	
Street Address		**Address**			
City	**State** / **Zip**	**City**	**State**	**Zip Code**	
Phone Number		**Phone Number**			
Contact Name		**RACE**	**ETHNICITY**	**Sex**	
		☐ American Indian/Alaska Native ☐ Asian ☐ Black ☐ Pacific Islander/ Hawaiian ☐ White/ Caucasian ☐ Other	☐ Hispanic or Latino ☐ Non-Hispanic or Latino	☐ Male ☐ Female	
Contact Phone Number					

Test Requested:

☐ Carbapenem-Resistant Enterobacteriaceae (CRE) Confirmation, Specify genus and species _____

☐ Carbapenem-Resistant *Pseudomonas aeruginosa* (CRPA) Confirmation

☐ Carbapenem-Resistant *Acinetobacter baumannii* (CRAB) Confirmation

Isolate Source: _____ **Site:** _____ Date **of Collection:** _____

Original Submitting Facility (e.g., clinic, hospital, nursing home), if different from submitter listed above:

Facility Name: _____ Street Address:_____

Patient Status: ☐ In-Patient/Resident of LTCF ☐ Outpatient ☐ Discharged ☐ Deceased

If Outpatient, please choose the discharge code: _____

If Discharged, note facility type: ☐ Home ☐ Hospital/Step down care ☐ Long Term Care Facility ☐ Prison/Jail ☐ Other _____

Required Testing Information:

Type of Commercial AST Instrument used: ☐ Microscan ☐ Phoenix ☐ Vitek-2 ☐ Trek Sensititre ☐ Other_____

Please attach your automated AST report.

If any of the following tests were also performed, please include your results below.

Phenotypic Carbapenemase Test (if performed): ☐**mCIM** ☐**CIM** ☐**MHT** ☐**Carba NP**

Phenotypic Results: ☐ **Positive** ☐ **Negative** ☐ **Indeterminate**

Molecular Carbapenemase Test (circle if performed): ☐ **Cepheid-Carba-R** ☐**Verigene** ☐**Biofire** ☐**Other:_____**

Molecular Results: ☐ **Positive** ☐ **Negative** If positive, select one: ☐ KPC ☐NDM ☐VIM ☐IMP ☐ OXA Other:____

E-test:

Antibiotic: _____ MIC: _____ Interp:_____

Antibiotic: _____ MIC: _____ Interp:_____

Disk Diffusion

Antibiotic: _____ Zone Size:_____ Interp: _____

Antibiotic: _____ Zone Size:_____ Interp: _____

Results for any of the following:

Tigecycline MIC: _____ Zone Size: _____ Interp: _____

Colistin MIC: _____ Zone Size:_____ Interp: _____

Polymyxin B MIC:_____ Zone Size: _____ Interp: _____

Instructions for Form 1042, CRE, CRPA and CRAB Isolate Submission Requisition

Purpose

To collect submitter information, patient demographics and specimen information for isolates submitted for CRE, CRPA and CRAB antimicrobial resistance confirmation 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 AND MIDDLE INITIAL in sequence. The spelling of the 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.

Race – Check the box associated with the patient's race

Ethnicity- Check the appropriate box

Sex- Check the appropriate box (male or female)

Test Requested: Check the box by the appropriate test requested. Test should be selected based on the organism being submitted for confirmation (CRE, CRPA or CRAB).

Isolate Source: Enter source of original specimen (blood, urine, etc)

Isolate Site: Enter site of specimen sources if applicable (right, left)

Date of Collection: Provide in MM/DD/YY format.

Submitter Isolate Test Results

Type of Commercial AST Instrument used: Check the box associated with the instrument used to perform isolate identification. Please attached the all automated AST reports.

Modified Hodge Test (for Enterobacteriaceae): Record test results of any modified Hodge Test performed on the isolate by the submitting laboratory. Record whether the isolate was positive or negative and the antibiotic tested.

E-test result: Record all E-test results obtained at the submitting laboratory. Include the MIC, Interpretation (susceptible, intermediate, or resistant) and the antibiotic tested.

Disk Diffusion: Record all disk diffusion results obtained at the submitting laboratory. Include the zone size, Interpretation (susceptible, intermediate, or resistant) and the antibiotic tested.

Results for any the following: Record the MIC or Zone Size results obtained by the submitting laboratory for Colistin, Polymyxin, and Tigecycline.

Office Mechanics and Filing – This form should be completed each time an isolate of CRE, CRPA, or CRAB is submitted to the MPHL for confirmation testing. A form must accompany each specimen 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.

Retention Period – The MSDH Laboratory will retain the original form in accordance with Clinical Laboratory Improvement Amendments (CLIA) regulations.