



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

Phone 651-201-5200
 Fax 651-201-4538
 Sample Receiving 651-201-4953
 CLIA# 24D0651409

MDH Lab Use Only
 Condition:
 Ambient Barcode
 Refrigerated Label
 Frozen

Enhanced Pertussis Project 840

Clinical Testing and Submission Form

* Required Fields

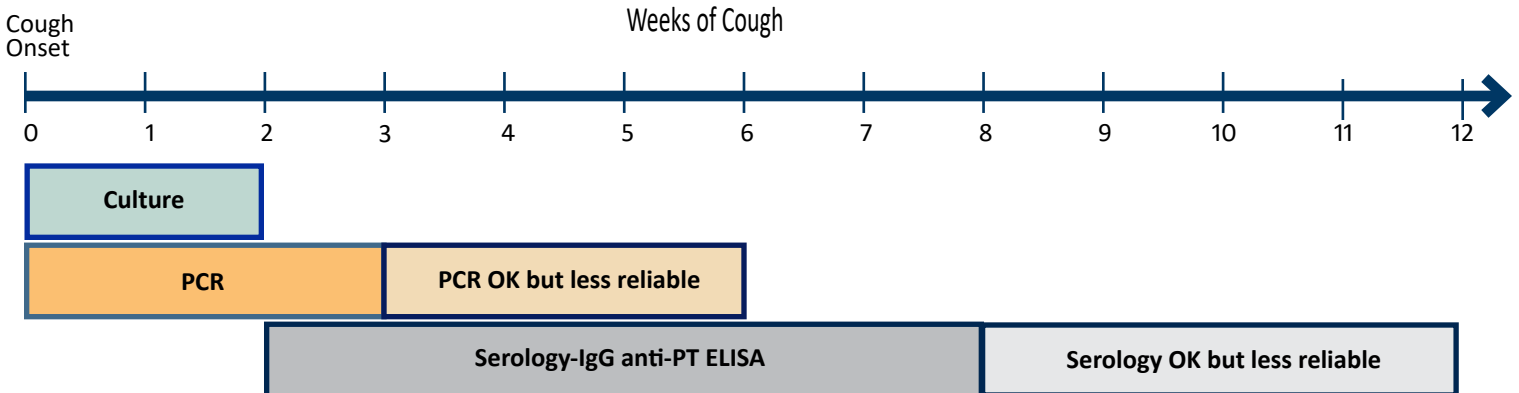
Submitter	*Submitting Facility: _____	Test and Source Information	Submitter Sample ID#: _____						
	*Address: _____		*Date of Collection (mm/dd/yyyy): _____						
	City: _____ State: _____ Zip: _____		Time of Collection: _____ AM PM (##:##)						
	Name of Person Filling Out Form: _____		Submitting Lab Organism/Result: _____						
	Phone: _____		Source/Type: _____ Note: Nasal swab is not an acceptable source						
	Originating Facility Name: _____		<table style="width: 100%; border: none;"> <tr> <td style="padding: 2px;">Blood</td> <td style="padding: 2px;">Nasopharyngeal swab</td> </tr> <tr> <td style="padding: 2px;">Serum</td> <td style="padding: 2px;">Nasopharyngeal wash</td> </tr> <tr> <td style="padding: 2px;">Nasal wash</td> <td style="padding: 2px;">Other: _____</td> </tr> <tr> <td style="padding: 2px;">Nasopharyngeal aspirate</td> <td></td> </tr> </table>	Blood	Nasopharyngeal swab	Serum	Nasopharyngeal wash	Nasal wash	Other: _____
Blood	Nasopharyngeal swab								
Serum	Nasopharyngeal wash								
Nasal wash	Other: _____								
Nasopharyngeal aspirate									

Patient	*Last Name: _____	Choose Test Requested (TEST CODE):		
	*First Name: _____	<table style="width: 100%; border: none;"> <tr> <td style="padding: 2px;">Bordetella PCR (BORDPCR)</td> <td style="padding: 2px;">B. pertussis Anti-PT IgG (BPAPTEIA)</td> </tr> </table>	Bordetella PCR (BORDPCR)	B. pertussis Anti-PT IgG (BPAPTEIA)
	Bordetella PCR (BORDPCR)	B. pertussis Anti-PT IgG (BPAPTEIA)		
	Address: _____	Most recent pertussis vaccination date: _____		
	City: _____ State: _____ Zip: _____	Check any antibiotics prescribed: Azithromycin Clarithromycin		
	Patient MRN #: _____ Sex: _____	Erythromycin TMP-SMX Other: _____		
	*Date of Birth:(mm/dd/yyyy): _____	Number of days prescribed: _____		
	Race: _____ Ethnicity: _____	Start Date: _____		
Date of Visit: mm/dd/yyyy _____				

Cough Onset: mm/dd/yyyy OR Length of cough (days): _____

Paroxysmal cough
 Post-tussive vomiting
 Whoop
 Apnea

Optimal Timing for Diagnostic Testing Using MDH-PHL



PCR will detect non-viable organisms present, even in persons who have been treated with antimicrobials; however, false negatives can occur and are more common later in the illness.

(+) **Positive:** Confirms B. pertussis if clinical and/or exposure history supports the diagnosis of pertussis.

(-) **Negative:** If cough length was longer than 2 weeks at time of test, a negative PCR does not rule out B. pertussis infection.

Vaccination within 6 months prior to specimen collection may result in a false positive for serology. To avoid this, ask if patient knows the date of their most recent pertussis vaccine, if unknown: interpret serology with caution, OR consider PCR/clinical diagnosis