



District of Columbia • Department of Forensic Sciences • Public Health Laboratory
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General Laboratory Services Request Form
PHL Director: Anthony Tran, DrPH, MPH, D(ABMM)
CLIA#: 09D0968273



Patient Information

*Required Information

Last Name*	First Name*	Middle Initial	Suffix
Date of Birth* (MM/DD/YYYY)	Sex* <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	If Female, Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Address	City*	State*	ZIP
Sample ID (Laboratory ID, Outbreak#, Zika#, etc.)*	Medical Record Number		

Submitter Information

Name of Submitting Hospital, Laboratory, or other Facility*		Healthcare Provider NPI #*	
Health Care Provider	Last Name*	First Name*	
Address (include room)*		City*	State* Zip*
Primary Contact (If not the Health Care Provider)	Last Name	First Name	
Telephone #* (primary)	Secure Fax #**	Email	

** Final report will be sent to the fax number above

Specimen Information

Date of Collection* (MM/DD/YYYY):	Time of Collection*: <input type="checkbox"/> AM <input type="checkbox"/> PM
Reason for Submission* <input type="checkbox"/> Diagnostic <input type="checkbox"/> Outbreak <input type="checkbox"/> DC Health Request: DC Health Contact: _____	
Specimen Type (check all that apply)* <input type="checkbox"/> Blood Culture Bottle <input type="checkbox"/> Isolate <input type="checkbox"/> Cary-Blair <input type="checkbox"/> E-Swab <input type="checkbox"/> Swab <input type="checkbox"/> UTM <input type="checkbox"/> VTM <input type="checkbox"/> Slide <input type="checkbox"/> Sterile Container <input type="checkbox"/> Blood Tube (Plasma, Serum or Whole Blood) _____ <input type="checkbox"/> Other (specify) _____	
Specimen Source* <input type="checkbox"/> Abscess <input type="checkbox"/> Blood <input type="checkbox"/> Bronchoalveolar Lavage <input type="checkbox"/> Bronchial Wash <input type="checkbox"/> Buccal <input type="checkbox"/> CSF <input type="checkbox"/> Endocervical <input type="checkbox"/> Nasopharynx (NP) <input type="checkbox"/> Oropharynx (OP) <input type="checkbox"/> NP/OP <input type="checkbox"/> Plasma <input type="checkbox"/> Rectal <input type="checkbox"/> Serum <input type="checkbox"/> Sputum, expectoration <input type="checkbox"/> Sputum, induced <input type="checkbox"/> Stool <input type="checkbox"/> Throat <input type="checkbox"/> Tissue <input type="checkbox"/> Urethral <input type="checkbox"/> Urine <input type="checkbox"/> Vaginal <input type="checkbox"/> Other (specify) _____	

Test Request (✓ requested tests)

BT RULE-OUT [§]	MOLECULAR
<input type="checkbox"/> <i>r/o B. anthracis</i>	<input type="checkbox"/> Ebola (PCR) ⁺
<input type="checkbox"/> <i>r/o Brucella sp.</i>	<input type="checkbox"/> Novel Influenza (PCR) ⁺
<input type="checkbox"/> <i>r/o Burkholderia sp.</i>	<input type="checkbox"/> Norovirus (PCR)
<input type="checkbox"/> <i>r/o F. tularensis</i>	<input type="checkbox"/> Middle East Respiratory Syndrome (MERS-CoV) (PCR) ⁺
<input type="checkbox"/> <i>r/o Y. pestis</i>	<input type="checkbox"/> <i>Chlamydia trachomatis</i> and <i>Neisseria gonorrhoeae</i> (TMA)
<input type="checkbox"/> Other(specify): _____	<input type="checkbox"/> Mumps (PCR) ⁺
MICROBIOLOGY/GENERAL BACTERIOLOGY	<input type="checkbox"/> Measles Virus (PCR) ⁺
<input type="checkbox"/> OCME	<input type="checkbox"/> Arbovirus Detection Panel (chikungunya, dengue and Zika) (PCR) ⁺
<input type="checkbox"/> Referred Isolates	<input type="checkbox"/> COVID-19 (PCR) ⁺
	SEROLOGY
	<input type="checkbox"/> Measles Virus (IgG) ⁺
	<input type="checkbox"/> Zika Virus (IgM) ⁺
	VIRAL CULTURE
	<input type="checkbox"/> Respiratory DFA with Reflex to Viral Culture (Adenovirus, Respiratory Syncytial Virus, Influenza A, Influenza B, Parainfluenza 1, 2 & 3)
OTHER TESTS	
<input type="checkbox"/> Test Name (specify) _____	

+ DC Health must approve testing prior to sending any isolate or specimen to the Public Health Laboratory
§ Call the Public Health Laboratory prior to sending any suspected isolate or specimen