



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	Patient Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Address	City*	State*	ZIP
Sample ID*	Medical Record Number		

Submitter Information

Name of Submitting Hospital, Laboratory, or other Facility*		Provider NPI/CLIA#*	
Primary Contact or Physician	Last Name*	First Name*	
Address (include room)*		City*	State* Zip*
Telephone*	Fax**	Email	

** As applicable, 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"/> DOH REQUEST: DOH 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"/> ESwab™ <input type="checkbox"/> Swab <input type="checkbox"/> Slide <input type="checkbox"/> Sterile Container <input type="checkbox"/> UTM <input type="checkbox"/> VTM <input type="checkbox"/> Blood Tube (plasma, Serum or Whole Food): _____ <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, induced <input type="checkbox"/> Sputum, expectorated <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 FOR RULE-OUT	MOLECULAR
<input type="checkbox"/> r/o <i>B. anthracis</i>	<input type="checkbox"/> Ebola (PCR) ⁺
<input type="checkbox"/> r/o <i>Brucella sp.</i>	<input type="checkbox"/> COVID-19 (PCR) ⁺
<input type="checkbox"/> r/o <i>Burkholderia sp.</i>	<input type="checkbox"/> Novel Influenza (PCR) ⁺
<input type="checkbox"/> r/o <i>F. tularensis</i>	<input type="checkbox"/> Norovirus (PCR)
<input type="checkbox"/> r/o <i>Y. pestis</i>	<input type="checkbox"/> Middle East Respiratory Syndrome (MERS-CoV) (PCR) ⁺
<input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> <i>Chlamydia trachomatis</i> and <i>Neisseria gonorrhoeae</i> (TMA)
MICROBIOLOGY/GENERAL BACTERIOLOGY	<input type="checkbox"/> Mumps (PCR)
<input type="checkbox"/> OCME	<input type="checkbox"/> Measles Virus (PCR) ⁺
Referred Isolates	<input type="checkbox"/> Arbovirus Detection Panel (chikungunya, dengue, zika) (PCR) ⁺
VIRAL CULTURE	SEROLOGY
<input type="checkbox"/> Respiratory DFA with Reflex to Viral Culture (Adenovirus, Respiratory Syncytial Virus, Influenza A, Influenza B, Parainfluenza 1, 2, & 3)	<input type="checkbox"/> Measles Virus (IgG) ⁺
	<input type="checkbox"/> Zika virus (IgM) ⁺
OTHER TESTS	
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	