



DC Public Health Laboratory

District of Columbia ♦ Department of Forensic Sciences ♦ Public Health Laboratory
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Surveillance Test Request

CLIA Laboratory Director: Julia Kiehlbauch Ph.D., D(ABMM)

Specimen Submitted by:

Hospital/Clinic _____
 Point-of-Contact Name _____
 Phone _____
 Fax _____
 E-mail _____
 Date _____ Time _____
 Address (include room) _____

Specimen Received By:

Courier Service _____
 Date & Time _____
 Initials _____

Specimen Type: (isolate, serum, etc)	Storage Temperature (Check one):			
	-70°C	-20°C	4°C	Room Temp
<input type="checkbox"/> <i>Salmonella</i>	<input type="checkbox"/> <i>Vibrio sp.</i>	<input type="checkbox"/> <i>Shigella sp.</i>	<input type="checkbox"/> <i>Listeria sp.</i>	<input type="checkbox"/> <i>Campylobacter sp.</i>
<input type="checkbox"/> Shiga Toxin-Producing <i>Escherichia coli</i> (STEC)	<input type="checkbox"/> Enteroinvasive <i>Escherichia coli</i> (EIEC)			
<input type="checkbox"/> Carbapenem- resistant <i>Enterobacteriaceae</i>	<input type="checkbox"/> Carbapenem- resistant <i>Pseudomonas aeruginosa</i>			
<input type="checkbox"/> Carbapenem- resistant <i>Acinetobacter baumannii</i>	<input type="checkbox"/> <i>Candida auris</i>			
<input type="checkbox"/> Other:				

**If submitting various specimens for different tests, please indicate the test being requested for each specimen in the comments section*

Unique Specimen Identifier	Last Name, First Name	Collection Date	Sex	Date of Birth	State of Residency	Comments

This section is for DC PHL use only

Specimens received by _____

Date/Time _____

Storage Temp _____