



New York City Department of Health and Mental Hygiene
PUBLIC HEALTH LABORATORY
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 455 First Avenue, New York, NY 10016
 NYS CLEP PERMIT #: PFI 3849 CLIA #: 33D0679872

PHL USE ONLY

LABORATORY TEST REQUEST

Microbiology Section: Tel 212-447-6783 Fax 212-447-8258
 Virology Section: Tel 212-447-2864 Fax 212-447-2877

- Failure to complete all required (*) fields may result in specimen being rejected
- Spelling of patient name and DOB on form must exactly match that on specimen container
- Complete a separate requisition form for each specimen

PATIENT INFORMATION

***Required Information**

LAST NAME*		FIRST NAME*		MIDDLE INITIAL	SUFFIX
DATE OF BIRTH* (MM/DD/YYYY)		GENDER* <input type="checkbox"/> Male <input type="checkbox"/> Female			
PATIENT ID NUMBER		PATIENT MEDICAL RECORD NUMBER*			
ADDRESS*			CITY*	STATE*	ZIP*
TELEPHONE		PHYSICIAN (If not submitter include contact info)			

SUBMITTER INFORMATION

NAME OF SUBMITTING HOSPITAL, LABORATORY, or OTHER FACILITY*			PROVIDER ID NUMBER		
PRIMARY CONTACT, or PHYSICIAN	LAST NAME*		FIRST NAME*		
ADDRESS (including bldg, and room)*			CITY*	STATE*	ZIP*
TELEPHONE*		PAGER/CELL*		FAX	

SPECIMEN INFORMATION

DATE OF COLLECTION* (MM/DD/YYYY)		TIME OF COLLECTION (00:00): <input type="checkbox"/> AM <input type="checkbox"/> PM			
REASON FOR SUBMISSION* <input type="checkbox"/> OUTBREAK <input type="checkbox"/> DOHMH REQUEST (if checked, complete A and B below)					
A. DOHMH BUREAU BOI				DOHMH INVESTIGATION CODE:	
B. DOHMH CONTACT	LAST NAME Rosen		FIRST NAME Jennifer		

MEASLES

	SEROLOGY	VIRUS IDENTIFICATION
TEST	<input type="checkbox"/> Measles IgG <input type="checkbox"/> Measles IgM	<input type="checkbox"/> Measles by PCR
SPECIMEN	<input type="checkbox"/> Blood Tube	<input type="checkbox"/> Swab-Viral Transport Media
SOURCE	<input type="checkbox"/> Blood <input type="checkbox"/> Serum	<input type="checkbox"/> Nasopharynx <input type="checkbox"/> Throat

MUMPS

	SEROLOGY	VIRUS IDENTIFICATION
TEST	<input type="checkbox"/> Mumps IgG <input type="checkbox"/> Mumps IgM	<input type="checkbox"/> Mumps by PCR
SPECIMEN	<input type="checkbox"/> Blood Tube	<input type="checkbox"/> Swab-Viral Transport Media
SOURCE	<input type="checkbox"/> Blood <input type="checkbox"/> Serum	<input type="checkbox"/> Buccal <input type="checkbox"/> Oropharynx

For DOH Use: SEND OUT TEST

Separate forms must be completed for blood and swab specimen
Test, specimen and source section must be completed for the specimen submitted