Division of Microbiology-NYC DOHMH
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NYC Health

MOLECULAR TYPING

PUBLIC HEALTH LABORATORY TEST REQUEST

FOR LAB USE ONLY

Please print clearly: DATE* (MM/DD/YYYY): :

* REQUIRED INFORMATION

1. SAMPLE INFORMATION

For PHL only	Sample ID	Source of Culture	Date of Culture (MM/DD/YYYY)	Ward of Isolation	Comments

2. SUBMITTER INFORMATION

NAME OF SUBMITTING HOSPITAL, LABORATORY, or OTHER FACILITY Etc.*: | PROVIDER ID#:

PRIMARY CONTACT or PHYSICIAN- LAST NAME*: | FIRST NAME*:

ADDRESS*:

CITY*: | STATE*: | ZIP*:

TELEPHONE*: | Pager/Cell*: | Fax: | EMAIL:

3. SPECIMEN INFORMATION

Reason for submission*	☐ OUTBREAK ☐ SURVEILLANCE ☐ DOHMH REQUEST **(if checked complete A & B)**
A. DOHMH bureau	☐ BCD ☐ BOI ☐ OEI ☐ OTHER (specify): DOHMH EVENT CODE:
B. DOHMH contact	Last Name: First Name:
Is this submission for referral?*	☐ NO ☐ YES (IF YES CHECK ONE): ☐ NYS ☐ CDC ☐ OTHER (specify):
Specimen type	Requirement for submission: **Pure culture of the organism identified to the species level.** Specify:
Additional comments	

4. TEST(S) REQUESTED*

☐ PFGE (PULSED FIELD GEL ELECTROPHORESIS)	
☐ OTHER:	

LTR_MIC04_709

*Failure to provide the required information or any discrepancy relating to the specimen submitted, may result in an inability to test or a delay in the release of test results.