New York City Department of Health and Mental Hygiene
PUBLIC HEALTH LABORATORY
NYC DOHMH 455 First Avenue New York, NY
Microbiology Section: Tel 212.447-6783 Fax 212.447-8258
Virology Section: Tel 212.447-2864 Fax 212.447-2877
Jennifer Rakeman, Ph.D., Assistant Commissioner
NYS CLEP PERMIT # : PFI 3849 CLIA #: 33D0679872

LABORATORY TEST REQUEST

PHL USE ONLY

*Required Information

PATIENT INFORMATION

LAST NAME*	FIRST NAME*	MIDDLE INITIAL	SUFFIX

DATE OF BIRTH* (MM/DD/YYYY)

SEX * ☐ Male ☐ Female ☐ Transgender F → M ☐ Transgender M → F

RACE: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Other

ETHNICITY: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

AREA OF BIRTH: ☐ Africa ☐ Asia ☐ Caribbean ☐ Central America ☐ Europe ☐ Middle East ☐ North America ☐ South America

Country of Birth:

PATIENT ID NUMBER

PATIENT MEDICAL RECORD NUMBER*

PATIENT PREGNANT? ☐ Yes ☐ No ☐ Unknown

ADDRESS*	CITY*	STATE*	ZIP*

TELEPHONE

PHYSICIAN (if not submitter include contact info)

SUBMITTER INFORMATION

NAME OF SUBMITTING HOSPITAL, LABORATORY, or OTHER FACILITY*

PROVIDER ID #

PRIMARY CONTACT or PHYSICIAN — LAST NAME* — FIRST NAME*

ADDRESS (including bldg. and room)*	CITY*	STATE*	ZIP*

TELEPHONE*	PAGER/CELL*	FAX	EMAIL

SPECIMEN INFORMATION

DATE OF COLLECTION* (MM/DD/YYYY):

TIME OF COLLECTION (00:00): ☐ AM ☐ PM

Reason for submission* ☐ DIAGNOSTIC ☐ CONFIRMATORY ☐ OUTBREAK ☐ FOLLOW UP ☐ SURVEILLANCE ☐ DOHMH REQUEST (if checked, complete A & B below)

A. DOHMH bureau ☐ BCD ☐ BOI ☐ BSTI ☐ BTBC ☐ OEI ☐ OTHER (specify)

DOHMH INVESTIGATION CODE:

B. DOHMH contact — Last Name — First Name

Specimen type * ☐ Blood Culture Bottles ☐ Blood tube ☐ Isolate ☐ Para-Pak ☐ Primary Specimen ☐ Slide ☐ Sterile Container ☐ Swab ☐ Swab-VTM ☐ Swab ☐ UPT ☐ Other (specify)

Specimen source ☐ Abscess ☐ Anorectal ☐ Blood ☐ Body fluid ☐ Bronchial wash ☐ Cervix ☐ CSF ☐ Genital ☐ Nasopharynx ☐ Oropharynx ☐ Plasma ☐ Respiratory ☐ Serum ☐ Sputum ☐ Sputum, induced ☐ Stool ☐ Throat ☐ Tissue/lesion ☐ Urethral ☐ Urine ☐ Wound ☐ Other (specify)

Additional comments/ Clinical syndrome

Date of symptom onset: (MM/DD/YYYY)

MICROBIOLOGY

AFB

- ☐ *First time diagnosis*
- ☐ *Previously MTB Positive*
- ☐ Primary culture
- ☐ Primary culture + NAAT
- ☐ Referral culture ID
- ☐ Referral culture ID & AST
- ☐ Referral NAAT + culture
- ☐ Genotyping

BIOTHREAT AGENTS

- ☐ *B. anthracis* ID
- ☐ *Brucella spp.* ID
- ☐ *Burkholderia mallei* ID
- ☐ *Burkholderia pseudomallei* ID
- ☐ *F. tularensis* ID
- ☐ r/o *Smallpox*
- ☐ *Y. pestis* ID
- ☐ *C. botulinum toxin* ID

ENTERIC BACTERIOLOGY

- ☐ *Campylobacter* spp. ID
- ☐ r/o STX *E. coli*
- ☐ Confirm STX *E. coli*
- ☐ *Salmonella* serotyping
- ☐ r/o *Salmonella typhi*
- ☐ *Shigella* serotyping & AST
- ☐ *Vibrio* spp. ID
- ☐ *Yersinia* spp. ID
- ☐ Enteric isolate ID - other
- ☐ Stool culture (BCD/OEI only)

STD MOLECULAR

- ☐ CT/NG by NAAT

MOLECULAR TYPING

- ☐ PFGE (submit pure culture; specify genus & species):

GENERAL BACTERIOLOGY

- ☐ GC culture
- ☐ Gen bacteriology isolate ID
- ☐ Gen bacteriology culture - OCME
- ☐ Antimicrobial susceptibility test (specify antibiotics):
- ☐ MRSA/VISA confirmation
- ☐ *H. influenza* serotyping
- ☐ *L. monocytogenes* serotyping
- ☐ *N. meningitidis* serotyping
- ☐ *B. pertussis* culture
- ☐ *Legionella* culture
- ☐ *Legionella* DFA only

VIROLOGY (DOHMH Authorized Only)

SEROLOGY

- ☐ West Nile Virus IgG
- ☐ West Nile Virus IgM
- ☐ HIV Serology
- ☐ Measles IgG
- ☐ Measles IgM
- ☐ Mumps IgG
- ☐ Mumps IgM
- ☐ Rubella IgG
- ☐ Rubella IgM
- ☐ Varicella-Zoster IgG
- ☐ Varicella-Zoster IgM
- ☐ Zika Serology
- ☐ Hepatitis A IgM
- ☐ Hepatitis A Total

VIRUS Identification

- ☐ Respiratory Panel
- ☐ Gastrointestinal Panel
- ☐ Influenza RT-PCR
- ☐ Measles RT-PCR
- ☐ Mumps RT- PCR
- ☐ MERS-CoV RT-PCR
- ☐ Dengue RT-PCR
- ☐ Norovirus RT-PCR
- ☐ Chikungunya RT-PCR
- ☐ Zika NAAT
- ☐ Virus Culture
  If isolate submitted, specify cell line:

☐ Other:

☐ Send out:

Rev_01/03/2019