District of Columbia ♦ Department of Forensic Sciences ♦ Public Health Laboratory
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General Laboratory Services Request Form

CLIA Laboratory Director: Jocelyn R. Hauser, Ph.D., D(ABMM), MLS(ASCP)CM
CLIA#: 09D0968273

Patient Information ***Required Information**

Last Name*	First Name*	Middle Initial	Suffix
Date of Birth* (MM/DD/YYYY)	Sex* ☐ Male ☐ Female ☐ Other	If Female, Pregnant ☐ Yes ☐ No ☐ Unknown	
Address*	City*	State*	Zip
Sample ID (Laboratory ID, Outbreak #, Zika #, etc.)*		Medical Record Number	

Submitter Information

Name of Submitting Hospital, Laboratory or Other *		Health Care Provider NPI #*	
Health Care Provider Last Name*		Health Care Provider First Name*	
Submitting Facility Address (include room)*	City*	State*	Zip*
Primary Contact Last Name (if not the Health Care Provider)	Primary Contact First Name (if not the Health Care Provider)		
Telephone #*	Secure Fax #**	Email**	

** Most reports are released through web portal. If applicable, final report will be sent to the fax number above or via secure email to the email address listed above

Specimen Information

Date of Collection* (MM/DD/YYYY) Time of Collection*: ☐ AM ☐ PM

Reason for Submission *
☐ Diagnostic ☐ Outbreak ☐ DC Health Request DC Health Contact: _____

Specimen Type (check all that apply)*
☐ Blood Culture Bottle ☐ Isolate ☐ Cary-Blair ☐ E-Swab ☐ Swab ☐ UTM ☐ VTM ☐ Slide ☐ Sterile Container ☐ Blood Tube (Plasma, Serum or Whole Blood ☐ Other (specify): _____

Specimen Source*
☐ Abscess ☐ Blood ☐ Bronchoalveolar Lavage ☐ Bronchial Wash ☐ Buccal ☐ CSF ☐ Endocervical ☐ Nasopharynx (NP) ☐ Oropharynx (OP) ☐ NP/OP ☐ Plasma ☐ Rectal ☐ Serum ☐ Sputum, expectoration ☐ Sputum, induced ☐ Stool ☐ Throat ☐ Tissue ☐ Urethral ☐ Urine ☐ Vaginal ☐ Other (specify): _____

Requested Test*

BT RULE-OUT+		**MOLECULAR**
☐ *r/o Bacillus anthracis*	☐ *r/o Francisella tularensis*	☐ Ebola (PCR)
☐ *r/o Brucella sp.*	☐ *r/o Yersinia pestis*	☐ Novel Influenza (PCR)
☐ *r/o Burkholderia sp.*	☐ *r/o Poxvirus*	☐ Norovirus (PCR)
☐ *r/o Viral Hemorrhagic Fever*	☐ Other:_____	☐ Middle East Respiratory Syndrome (MERS-CoV) (PCR)
MICROBIOLOGY/GENERAL BACTERIOLOGY		☐ Mumps (PCR)
☐ Referred Isolates		☐ Measles Virus (PCR)
SEROLOGY/IMMUNOLOGY		☐ Poxvirus (PCR)
☐ Measles Virus (IgG)		**VIROLOGY**
☐ SARS-CoV-2 (IgG)		☐ SARS-CoV-2 (NAAT)
OFFICE OF THE CHIEF MEDICAL EXAMINER ONLY		☐ Influenza A/B, Respiratory Syncytial virus Panel (NAAT)
☐ Bacteriology ☐ Respiratory Virus Panel ☐ SARS-CoV-2		☐ Parainfluenza 1-4 panel (NAAT)
CLINICAL TOXICOLOGY		☐ Respiratory DFA with Reflex to Viral Culture (Adenovirus, Respiratory Syncytial Virus, Influenza A, Influenza B, Parainfluenza 1, 2, 3)
☐ Urine Drugs of Abuse Screen 14-Drug Panel• (6AM, Amp, Meth, Barb, Benz, BUP, THC, Coc, Ecst, FENT, Opi, Oxy, PCP, TRAM) w/ Creat		☐ Zika Virus (TMA)
		☐ *Chlamydia trachomatis* and *Neisseria gonorrhoeae* (TMA)
OTHER TEST		
☐ Test Name:_____		☐ Send Out (Zika Virus IgM††, Dengue Virus PCR, Chikungunya Virus PCR, or other)
TESTING PRIORITY		
☐ Routine Test Requested		☐ STAT/Priority Test Requested