

	TOXICOLOGY PUBLIC HEALTH LABORATORY TEST REQUEST	FOR LAB USE ONLY
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Please print clearly: DATE* (MM/DD/YYYY): *** Required Information**

1. PATIENT INFORMATION		
PATIENT LAST NAME*:		PATIENT FIRST NAME*:
DATE OF BIRTH* (MM/DD/YYYY):	Sex*: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	PATIENT ID#/MEDICAL RECORD#:
ADDRESS:	CITY:	STATE: ZIP:
TELEPHONE:	PHYSICIAN: (if other than submitter)	Physician's pager/cell:

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

3. SPECIMEN INFORMATION		
DATE OF COLLECTION* (MM/DD/YYYY):		TIME OF COLLECTION* [00:00]: <input type="checkbox"/> AM <input type="checkbox"/> PM (where applicable)
Reason for submission*	<input type="checkbox"/> DIAGNOSTIC <input type="checkbox"/> CONFIRMATORY <input type="checkbox"/> LAW ENFORCEMENT Referral <input type="radio"/> NYPD <input type="radio"/> Other (specify):	
<input type="checkbox"/> Poison Control/DOHMH REQUEST (if checked, complete A & B below)		
A. Bureau	<input type="checkbox"/> PCC <input type="checkbox"/> LPP <input type="checkbox"/> BCD <input type="checkbox"/> OTHER (specify):	
B. Contact	DOHMH EVENT CODE:	
Last Name:		First Name:
Is this submission for referral?*	<input type="checkbox"/> NO <input type="checkbox"/> YES (IF YES CHECK ONE): <input type="checkbox"/> NYS <input type="checkbox"/> CDC <input type="checkbox"/> OTHER (specify):	
Specimen type*	<input type="checkbox"/> Blood <input type="checkbox"/> Serum <input type="checkbox"/> Plasma <input type="checkbox"/> Urine <input type="checkbox"/> Other (specify type):	
Additional test information*	Suspected source of toxin (specify):	

4. TEST(S) REQUESTED*		
<input type="checkbox"/> Alcohols (check for complete panel or select below) Please contact Dr. Michael Heller (212) 447-2694 prior to request. <input type="radio"/> Ethanol <input type="radio"/> Acetone <input type="radio"/> Isopropanol <input type="radio"/> Methanol	<input type="checkbox"/> Drugs of Abuse Screen (check for complete panel or select below) <input type="radio"/> Amphetamine <input type="radio"/> Methamphetamine <input type="radio"/> Barbiturates <input type="radio"/> Benzodiazapines <input type="radio"/> Cocaine/Metabolite <input type="radio"/> Codeine <input type="radio"/> Methadone <input type="radio"/> Methaqualone <input type="radio"/> Morphine <input type="radio"/> Phencyclidine <input type="radio"/> THC/Metabolite	<input type="checkbox"/> Glycols (check for complete panel or select below) Please contact Dr. Michael Heller (212) 447-2694 prior to request. <input type="radio"/> Ethylene <input type="radio"/> Polypropylene
		<input type="checkbox"/> Cholinesterase <input type="checkbox"/> Cyanide <input type="checkbox"/> Lead

LTR_ENV01_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.