

<b>NYC</b> Health	<b>PARASITOLOGY</b> PUBLIC HEALTH LABORATORY TEST REQUEST	FOR LAB USE ONLY
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**Please print clearly:** DATE \*(MM/DD/YYYY):  **\* Required information**

<b>1. PATIENT INFORMATION</b>			
PATIENT LAST NAME*:		PATIENT FIRST NAME*:	
<input style="width:100%;" type="text"/>		<input style="width:100%;" type="text"/>	
DATE OF BIRTH*(MM/DD/YYYY):	Sex*: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	PATIENT ID#/MEDICAL RECORD#:	
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	
ADDRESS:	CITY:	STATE:	ZIP:
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>
TELEPHONE:	PHYSICIAN: (if other than submitter)	Physician's pager/cell:	
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	

<b>2. SUBMITTER INFORMATION</b>			
NAME OF SUBMITTING HOSPITAL, LABORATORY, or OTHER FACILITY Etc.*:		PROVIDER ID#:	
<input style="width:100%;" type="text"/>		<input style="width:100%;" type="text"/>	
PRIMARY CONTACT or PHYSICIAN- LAST NAME*:		FIRST NAME*:	
<input style="width:100%;" type="text"/>		<input style="width:100%;" type="text"/>	
ADDRESS*:			
<input style="width:100%;" type="text"/>			
CITY*:		STATE*:	ZIP*:
<input style="width:100%;" type="text"/>		<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>
TELEPHONE*:	Pager/Cell*:	Fax:	EMAIL:
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>

<b>3. SPECIMEN INFORMATION</b>			
DATE OF COLLECTION*(MM/DD/YYYY):		TIME OF COLLECTION*(00:00):	
<input style="width:100%;" type="text"/>		<input style="width:100%;" type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM	
[where applicable]			
Reason for submission*	<input type="checkbox"/> DIAGNOSTIC <input type="checkbox"/> CONFIRMATORY <input type="checkbox"/> OUTBREAK <input type="checkbox"/> DOHMH REQUEST (if checked complete A & B below)		
A. DOHMH bureau	<input type="checkbox"/> BCD <input type="checkbox"/> BOI <input type="checkbox"/> OEI <input type="checkbox"/> OTHER (specify): <input style="width:100px;" type="text"/>		DOHMH EVENT CODE: <input style="width:100px;" type="text"/>
B. DOHMH contact	Last Name: <input style="width:100%;" type="text"/>		First Name: <input style="width:100%;" type="text"/>
Is this submission for referral?*	<input type="checkbox"/> NO <input type="checkbox"/> YES (IF YES CHECK ONE): <input type="radio"/> NYS <input type="radio"/> CDC <input type="radio"/> OTHER (specify): <input style="width:100px;" type="text"/>		
Specimen type*	<input type="checkbox"/> Clinical Specimen <input type="checkbox"/> Fixed specimen <input type="checkbox"/> Slide <input type="checkbox"/> Pinworm slide/paddle <input type="checkbox"/> Intact worm <input type="checkbox"/> Other: <input style="width:100px;" type="text"/>		
Specimen source*	<input type="checkbox"/> Stool <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Tissue <input type="checkbox"/> Other (specify): <input style="width:100px;" type="text"/>		
Additional testing information:*	Preliminary ID: <input style="width:100%;" type="text"/>		
Additional comments	<input style="width:100%;" type="text"/>		

<b>4. TEST(S) REQUESTED*</b>	
<input type="checkbox"/> Cryptosporidium/Cyclospora (Stool Exam)	<input type="checkbox"/> Pinworm (Microscopic)
<input type="checkbox"/> Helminth (Worm) Identification	<input type="checkbox"/> Trichinella Detection
<input type="checkbox"/> Malaria/Babesia (Blood exam)	<input type="checkbox"/> Serology (specify): <input style="width:100px;" type="text"/>
<input type="checkbox"/> Ova & Parasites (Stool/Urine)	<input type="checkbox"/> PCR (specify): <input style="width:100px;" type="text"/>
<input type="checkbox"/> Parasite Identification (Blood/Tissue)	<input type="checkbox"/> Other (specify): <input style="width:100px;" type="text"/>

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\*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.