US. ARMY MEDICAL RESEARCH INSTITUTE OF CHEMICAL DEFENSE CLINICAL LABORATORY
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# TEST REQUISITION FORM

**Today's Date:** _____

**Patient full name:** _____ **Sex:** ☐M ☐F

**Patient 2ND Identifier:** _____ **Date of Birth:** _____
DoDID (preferred)/SSN (indicate which)

**Test Requested:** Blister Agent Exposure -

**Requesting Provider (including credentials):** _____

**Requesting Provider unit/email address/phone:**

**Date & Time Specimen Collected:** _____

**Specimen Source (heparin plasma preferred):** _____

**Relevant History surrounding events preceding collection:**

**Date/time of suspected exposure:** _____ **Date initial treatment:** _____

**Has the patient received antidote?** _____ **Date/time antidote given:** _____

**Type of antidote(s) given, if any:** _____

**Is the DD FORM 1911 completed?** ☐Y ☐N

**Have you contacted USAMRICD? How? (ie., SIPR, NIPR, phone)** _____

**Does the specimen label contain the following?**

**Two patient identifiers:** ☐Y ☐N **Date/time collected:** ☐Y ☐N

**Additional Notes:**

**Signature of requesting provider:** _____