US. ARMY MEDICAL RESEARCH INSTITUTE OF CHEMICAL DEFENSE CLINICAL LABORATORY
8350 RICKETTS POINT ROAD, ABERDEEN PROVING GROUND, MD 21010-5400
(410) 652-4785 or (410) 652-2745

TEST REQUEST FORM

Today's Date: _____

Patient full name: _____ **Date of Birth:** _____ **Sex: M / F**

Patient 2ND Identifier: _____ (DOD ID# [preferred], SSN, indicate which)

Test Requested: _____

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: _____

Is the DD FORM 1911 completed? _____

Have you contacted MRICD? How? (ie., NIPR, phone) _____

Does the specimen label contain the following?

Two patient identifiers: _____

Date/time collected: _____

If specimen collected in anything other than heparinized blood tube, please indicate here how collected:

_____

Signature of requesting provider: _____