MUMPS Swab (PCR)

Label Tubes With: Full Name, DOB, Collection Date

New York City Department of Health and Mental Hygiene
PUBLIC HEALTH LABORATORY
Jennifer Rakeman, Ph.D., Assistant Commissioner
455 First Avenue, New York, NY 10016
NYS CLEP PERMIT #: PFI 3849 CLIA #: 33D0679872

LABORATORY TEST REQUEST
Microbiology Section: Tel 212-447-6783 Fax 212-447-8258
Virology Section: Tel 212-447-2864 Fax 212-447-2877

PHL USE ONLY

- **Failure to complete all required (*) fields may result in specimen being rejected**
- **Spelling of patient name and DOB on form must exactly match that on specimen container**
- **Complete a separate requisition form for each specimen**

PATIENT INFORMATION

***Required Information**

LAST NAME*	**FIRST NAME***	MIDDLE INITIAL	SUFFIX

DATE OF BIRTH* **(MM/DD/YYYY)**	**GENDER*** ☐ Male ☐ Female
PATIENT ID NUMBER	PATIENT MEDICAL RECORD NUMBER*

ADDRESS*	CITY*	STATE*	ZIP*

TELEPHONE	PHYSICIAN (If not submitter include contact info)

SUBMITTER INFORMATION

NAME OF SUBMITTING HOSPITAL, LABORATORY, or OTHER FACILITY*		PROVIDER ID NUMBER
PRIMARY CONTACT, or PHYSICIAN	LAST NAME*	FIRST NAME*

ADDRESS (including bldg, and room)*	CITY*	STATE*	ZIP*

TELEPHONE*	PAGER/CELL*	FAX

SPECIMEN INFORMATION

DATE OF COLLECTION* (MM/DD/YYYY)	TIME OF COLLECTION (00:00): ☐ AM ☐ PM

REASON FOR SUBMISSION* ☐ OUTBREAK ☑ DOHMH REQUEST (if checked, complete A and B below)

A. DOHMH BUREAU	DOHMH INVESTIGATION CODE:
BOI	

B. DOHMH CONTACT	LAST NAME	FIRST NAME
	Rosen	Jennifer

MEASLES

	SEROLOGY	VIRUS IDENTIFICATION
TEST	☐ Measles IgG ☐ Measles IgM	☐ Measles by PCR
SPECIMEN	☐ Blood Tube	☐ Swab-Viral Transport Media
SOURCE	☐ Blood ☐ Serum	☐ Nasopharynx ☐ Throat

MUMPS

	SEROLOGY	VIRUS IDENTIFICATION
TEST	☐ Mumps IgG ☐ Mumps IgM	☑ Mumps by PCR
SPECIMEN	☐ Blood Tube	☑ Swab-Viral Transport Media
SOURCE	☐ Blood ☐ Serum	☑ Buccal ☐ Oropharynx

For DOH Use: ☐ SEND OUT TEST

Separate forms must be completed for blood and swab specimen
Test, specimen and source section must be completed for the specimen submitted