

CHEMICAL EMERGENCY TEST REQUEST FORM

UTAH PUBLIC HEALTH LABORATORY

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<http://uphl.at.utah.gov/>

FOR UPHL USE ONLY

Sample rejected? (circle) Y or N If yes- attach sample rejection form

LAB#

DATE STAMP:

PLEASE PRINT CLEARLY AND FILL OUT AS COMPLETELY AS POSSIBLE.

PATIENT INFORMATION:

| | | | |
|--------------------|-----------|----------------------------------------------|-------------------------------------|
| PATIENT LAST NAME: | ZIP CODE: | DATE OF BIRTH (mm/dd/yyyy) ____/____/____ | GENDER (circle) Male Female |
|--------------------|-----------|----------------------------------------------|-------------------------------------|

| | | |
|---------------------|-----------------------------|------------------------------|
| PATIENT FIRST NAME: | PATIENT STATE OF RESIDENCE: | PATIENT COUNTY OF RESIDENCE: |
|---------------------|-----------------------------|------------------------------|

| | |
|----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| PATIENT ID # Provider Code: | PROVIDER INFORMATION Physician/Clinician Name: _____ Provider Address: _____ Provider Phone: _____ Secure Fax #: _____ Provider email: _____ |
|----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|

| | | |
|------------------------------------------------------------------------------------------|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| SPECIMEN COLLECTION DATE AND TIME (mm/dd/yy) ____/____/____ Time: _____ | Specimen Source (circle) Blood Serum Urine | Chemical Threat Tests <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;">[] TES</div> <div style="width: 33%;">[] OPNA</div> <div style="width: 33%;">[] BM</div> <div style="width: 33%;">[] VOC</div> <div style="width: 33%;">[] TET</div> <div style="width: 33%;">[] SO</div> <div style="width: 33%;">[] CYANIDE</div> <div style="width: 33%;">[] AB/RIC</div> <div style="width: 33%;">[] OTHER - SPECIFY BELOW</div> </div> |
|------------------------------------------------------------------------------------------|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

ADDRESS OR GENERAL LOCATION OF CHEMICAL EMERGENCY EVENT:
LOCATION OF PATIENT DURING CHEMICAL EMERGENCY EVENT:
COMMENTS: