

Leishmania Diagnostics Laboratory
 Diagnostics and Countermeasures Branch
 Center of Infectious Disease Research
 Walter Reed Army Institute of Research
 503 Robert Grant Avenue, Silver Spring, MD 20910
 Phone (240) 595-7353 – Fax (301) 319-9997

Leishmaniasis Test Request Form (CONUS)

Please fill the request form completely to ensure timely specimen processing.

Test Requested (Check one)	Specimen Requirement	Draw Tube/ medium	Lesion Location # of Lesions	Shipping Conditions (Check one)
<input type="checkbox"/> rK39 - Kalazar <i>Detect</i> TM Rapid Test (VL)	<input type="checkbox"/> 1-2 ml serum	<input type="checkbox"/> SST Tubes <input type="checkbox"/> Red-top tube		<input type="checkbox"/> 2-8° C post-centrifugation, shipped in cold box with ice packs
<input type="checkbox"/> Histopathology (Smear ONLY)	<input type="checkbox"/> Dermal Scrapings <input type="checkbox"/> Touch prep-impression smears	<input type="checkbox"/> Microscope Slides		<input type="checkbox"/> Ambient 15-30°C <input type="checkbox"/> Fixed with alcohol <input type="checkbox"/> Stained Slides
<input type="checkbox"/> Molecular test	<input type="checkbox"/> Dermal Scrapings <input type="checkbox"/> Punch Biopsy <input type="checkbox"/> Shavings <input type="checkbox"/> Needle Aspirates <input type="checkbox"/> Bone Marrow (VL)	<input type="checkbox"/> 70-100% Ethanol <input type="checkbox"/> Methanol <input type="checkbox"/> Isopropanol		<input type="checkbox"/> Ambient 15-30°C
<input type="checkbox"/> Culture	<input type="checkbox"/> Dermal Scrapings <input type="checkbox"/> Punch Biopsy <input type="checkbox"/> Needle Aspirates <input type="checkbox"/> Bone Marrow (VL)	<input type="checkbox"/> LDL Schneider's medium <input type="checkbox"/> RPMI		<input type="checkbox"/> Ambient 15-30°C

Travel History:

Clinical History:

Please include lesion location(s), duration of lesion and clinical appearance (nodule, ulcer, plaque, other, describe please)

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PATIENT IDENTIFICATION	CONTACT INFORMATION	
Patient identifiers <u>MUST INCLUDE:</u> Full Name _____ DoD# _____ DOB _____ Draw Date _____ Antibiotic Treatment (Type/dose/length): _____	Clinic/Center/MTF _____ Address _____ Physician Name _____ Phone _____ Fax _____ Email _____ Alternate POC Name _____ Alternate POC Phone _____ Alternate POC Email _____	
PROCESSING LAB (For LDL use only)		
BARCODE	DATE RECEIVED/LDL #/Initials	Quantity & Type Received

Email (usarmy.detrick.medcom-wrair.mbx.leishmania-diagnostic@health.mil) a FedEx tracking number to ensure all shipments sent to the LDL are received, IAW CAP GEN.40530