

Leishmaniasis Test Request Form (OCONUS)

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 Detect™ 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 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"/> 70-100% Ethanol <input type="checkbox"/> Methanol <input type="checkbox"/> Isopropanol		<input type="checkbox"/> Ambient 15-30°C

**** Please Consult with your dermatologist or with LDL clinical consultant**

Travel History:

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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# _____ SSN _____ 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