Date Received:

STATE OF IDAHO BUREAU OF LABORATORIES
2220 OLD PENITENTIARY ROAD
BOISE, IDAHO 83712-8299
(208) 334-2235

Molecular Strain Typing Test Request Form
FOR _____
(ORGANISM IDENTIFICATION)

Isolate

#1. Name_____ID#_____DOB __/__/__ M F
LAST FIRST

Source_____ Date of Collection __/__/__

#2. Name_____ID#_____DOB __/__/__ M F
LAST FIRST

Source_____ Date of Collection __/__/__

#3. Name_____ID#_____DOB __/__/__ M F
LAST FIRST

Source_____ Date of Collection __/__/__

#4. Name_____ID#_____DOB __/__/__ M F
LAST FIRST

Source_____ Date of Collection __/__/__

#5. Name_____ID#_____DOB __/__/__ M F
LAST FIRST

Source_____ Date of Collection __/__/__

Suspected Source of Infection _____Nosocomial? □ Yes □No □Unknown

******PLEASE ATTACH COPIES OF ANTIMICROBIAL SUSCEPTIBILITIES FOR ISOLATES***

Send report to:

Facility _____
Attention _____
Address _____
City/State/Zip _____
Phone_____

Send copy to:

Facility _____
Attention _____
Address _____
City/State/Zip _____
Phone _____

Revised 10/16/13