



GEORGIA DEPARTMENT OF PUBLIC HEALTH
PUBLIC HEALTH LABORATORY

CHEMICAL THREAT SUBMISSION FORM

SUBMITTER INFORMATION	PATIENT INFORMATION
SUBMITTER CODE: <div style="display: flex; justify-content: space-around; width: 100%;"> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> NAME: _____ STREET: _____ CITY: _____ STATE & ZIP CODE: _____ PHONE NO: _____ FAX NO: _____ CONTACT NAME: _____ _____	PATIENT ID: _____ NAME: _____ <div style="display: flex; justify-content: space-around; width: 100%; font-size: small;"> Last First Middle </div> RESIDENCE: _____ <div style="display: flex; justify-content: space-around; width: 100%; font-size: small;"> Street City State Zip </div> PHONE: _____ <div style="display: flex; justify-content: space-around; width: 100%; font-size: small;"> County Home Work Cell/other </div> DOB: ____/____/____ Medicaid # _____ RACE: ETHNICITY: GENDER: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Male <input type="checkbox"/> Asian <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Female <input type="checkbox"/> Black/African-American <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> White

SPECIMEN/CLINICAL INFORMATION		
Date of collection: ____/____/____ Time of collection: _____ Total urine volume _____ mL Urine creatinine (if applicable) _____ Blood Number of tubes w/ EDTA : _____ Number of tubes w/ Heparin: _____ Shipped: <input type="checkbox"/> Frozen (urine only) <input type="checkbox"/> Refrigerated (blood only)	Clinical information: Patient location at time of collection: <input type="checkbox"/> Inpatient Hospital name _____ _____ <input type="checkbox"/> Outpatient <input type="checkbox"/> Long term care Illness related to chemical exposure: <input type="checkbox"/> Yes <input type="checkbox"/> No Name/ID number of event: _____	Symptoms: (check all that apply) <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> Backache <input type="checkbox"/> Blurred vision <input type="checkbox"/> Chest pain <input type="checkbox"/> Constipation <input type="checkbox"/> Cough <input type="checkbox"/> Diarrhea <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Disordered speech <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Headache <input type="checkbox"/> Hemorrhage </div> <div style="width: 50%;"> <input type="checkbox"/> Joint pain <input type="checkbox"/> Myalgia <input type="checkbox"/> Nausea <input type="checkbox"/> Necrosis <input type="checkbox"/> Vomiting <input type="checkbox"/> Rash <input type="checkbox"/> Sore throat <input type="checkbox"/> Stiff neck <input type="checkbox"/> Swollen lymph nodes <input type="checkbox"/> Watery/red/itchy eyes <input type="checkbox"/> Weight loss <input type="checkbox"/> Other _____ </div> </div>

Please select ONLY one TEST per SPECIMEN per FORM

Test requested	Results
<input type="checkbox"/> Rapid toxic screen ** <input type="checkbox"/> Cadmium, mercury and lead (blood)* <input type="checkbox"/> Toxic elements panel (urine) * <input type="checkbox"/> Arsenic (urine) * <input type="checkbox"/> Mercury (urine)* <input type="checkbox"/> Cyanide (blood)* <input type="checkbox"/> Volatile organic compounds (VOC) (blood)* <input type="checkbox"/> Tetramine (urine)* <input type="checkbox"/> Organophosphate nerve agent metabolites (OPNA) (urine)* <input type="checkbox"/> Metabolic toxins panel (MTP) (urine)* <input type="checkbox"/> Atrine and ricinine (urine)* <input type="checkbox"/> Hold for testing* **performed at the Centers for Disease Control (CDC) *consultation with GPL Emergency Response Coordinator required. 24/7 contact number – 1-800-806-1376 (pager)	Date reported: _____ Reported by: _____