

**OFFICE OF LABORATORY SERVICES**

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PLACE BARCODE HERE

OLS USE ONLY

**THREAT-PREPAREDNESS AND BIOTERRORISM ENVIRONMENTAL SAMPLE SUBMISSION FORM**

**INSTRUCTIONS:** Before authorization to send samples is given, you **MUST** follow the West Virginia Threat Assessment and Notification Procedure for Suspected Bioterrorism Incidents. Specimens submitted for testing **MUST** include this fully completed submission form. Use one form per source. You **MUST** receive verbal permission from the Threat-Preparedness & Bioterrorism Response Section (BT Lab) prior to sending any specimens. Use this form **only** for samples submitted to the BT Lab for identifying potential Bioterrorism Agents. When requesting results, please refer to the EOC Message Number provided by the WV Department of Homeland Security and Emergency Management (WVDHSEM). You **MUST** also include a Chain of Custody document for each sample submitted. **Please print or type answers.**

**SAMPLE INFORMATION**

DATE OF COLLECTION	TIME OF COLLECTION <input type="checkbox"/> AM <input type="checkbox"/> PM
DESCRIPTION OF SAMPLE	
INCIDENT DESCRIPTION	
INCIDENT STREET ADDRESS	INCIDENT COUNTY
DETERMINED LEVEL OF RISK <input type="checkbox"/> High Priority <input type="checkbox"/> Moderate Priority <input type="checkbox"/> Low Priority	
RISK ASSESSMENT PERFORMED BY (include credentials)	
ANY ASSOCIATED ILLNESS OR SYMPTOMS? <input type="checkbox"/> Yes Describe _____ <input type="checkbox"/> No	

**SUSPECTED ORGANISM(S) or AGENT**

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**MANDATORY PRIOR NOTIFICATION INFORMATION**

WVDHSEM EMERGENCY OPERATION CTR (EOC)	CONTACT NAME	DATE <input type="checkbox"/> AM <input type="checkbox"/> PM
	EOC MESSAGE #:	TIME <input type="checkbox"/> AM <input type="checkbox"/> PM
LOCAL HEALTH DEPT	CONTACT NAME	DATE <input type="checkbox"/> AM <input type="checkbox"/> PM
	COUNTY	TIME <input type="checkbox"/> AM <input type="checkbox"/> PM
INFECTIOUS DISEASE EPIDEMIOLOGY (IDEP)	CONTACT NAME	DATE <input type="checkbox"/> AM <input type="checkbox"/> PM
OFFICE OF LAB SERVICES (OLS) BT LAB	CONTACT NAME	DATE <input type="checkbox"/> AM <input type="checkbox"/> PM
		TIME <input type="checkbox"/> AM <input type="checkbox"/> PM
OTHER AGENCIES CONTACTED	CONTACT NAME	DATE <input type="checkbox"/> AM <input type="checkbox"/> PM
		TIME <input type="checkbox"/> AM <input type="checkbox"/> PM

**SUBMITTER INFORMATION**

SUBMITTER AGENCY		
SUBMITTER NAME and RANK	EMPLOYMENT ID (Badge #, etc)	
EMPLOYMENT STREET ADDRESS		
CITY	STATE	ZIP
COUNTY	EMAIL	
PHONE NO.	FAX NO.	
NAME OF PERSON WHO SHOULD RECEIVE REPORT AT FACILITY		

**SAMPLE TRIAGE**

<b>PHYSICAL INDICATORS &amp; OTHER OUTWARD WARNING SIGNS:</b>
<input type="checkbox"/> Medical mass casualty / fatality with minimal or no trauma
<input type="checkbox"/> Responder casualties
<input type="checkbox"/> Dead animals, insects, and/or vegetation
<input type="checkbox"/> Unusual odors, color of smoke, vapor clouds
<input type="checkbox"/> Other (explain):

**DISPERSAL METHOD:**

<input type="checkbox"/> Air handling system (building)	<input type="checkbox"/> Sprayer
<input type="checkbox"/> Misting or aerosolizing device	<input type="checkbox"/> Gas Cylinder
<input type="checkbox"/> Dirty bomb	<input type="checkbox"/> No Device Found
<input type="checkbox"/> Other (explain):	

ON-SITE SCREEN	Method/Instrument	Date/Time	Results	Tech ID
X-Ray <input type="checkbox"/> Yes <input type="checkbox"/> No				
Hand Held Assay (HHA) <input type="checkbox"/> Yes <input type="checkbox"/> No				
Radioactivity <input type="checkbox"/> Yes <input type="checkbox"/> No				
Chemical <input type="checkbox"/> Yes <input type="checkbox"/> No				

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RESULTS REPORTED TO	DATE REPORTED	TECH INITIALS
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Signature of Submitter

Date

FAILURE TO COMPLETE THIS FORM IN ITS ENTIRETY MAY RESULT IN DELAYED TEST RESULTS