Laboratory Specialists, Inc. Isolate Submission Form

Please complete one form per patient and return with isolates in the shipment box provided

Submitting Laboratory Information[1]:

Contact Name/Department: _____

Institution Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Email: _____

LSI Use Only

LSI Bank #_____

Drug Requested for Susceptibility Testing: _____

***Any retesting, due to issues outside of our control, may be subject to additional testing costs**

Isolate and De-Identified Patient Information (PLEASE DO NOT INCLUDE PATIENT NAME):

Isolate Reference Number (can be an accession number): _____

Organism Identification: _____

Specimen Source: _____

Patient DOB: _____

Specimen Collection: Date: _____ Time: _____

Other Comments**:** _____

Was susceptibility testing performed? _____ If so, what was the MIC/Zone result? _____ µg/mL/mm

What testing system was used? (i.e. Etest, MTS, BMD or Disk) _____

PAYMENT OPTIONS (Please check one):

Purchase Order ☐

#: _____

(**must be provided before isolate can be processed or tested, unless credit card payment is chosen**)

Credit Card* ☐

*a 3.5% service fee will be charged for all credit card payments

Credit card authorization form must be completed and either faxed or included with the isolate shipment

Billing Contact:

Contact Name _____

Department _____

Institution Name _____

Address _____

City_____ State _____ Zip _____

Phone: _____ Fax: _____ Email: _____

SHIP ISOLATES TO*: Laboratory Specialists, Inc.

26214 Center Ridge Road, Westlake, OH 44145

Ph: 440-835-4458 Fax: 440-835-5786 Email: info@labspec.org

***the shipment MUST conform to current IATA regulations and include an LSI submission form**

[1]By sending an isolate to Laboratory Specialists, Inc., you acknowledge that Laboratory Specialists, Inc., may perform additional research on the isolate. The results of any such research may be published. To the extent reasonably practical, any such publication will acknowledge the source of the isolate.

Credit Card Payment Authorization

Sign and complete this form to authorize Laboratory Specialists, Inc. to make a one-time charge to your credit card listed below. By signing this form, you give us permission to debit your account for the amount owed on or after the indicated date. This is permission for a single transaction only.

I _____ authorize Laboratory Specialists, Inc. to charge the
(Cardholder's Full Name)
credit card account indicated below. This payment is for:

_____
(Description of Goods/Services)

Authorized amount: $_____ (**a 3.5% service charge will be added**)

Cardholder's Billing Information:

Institution _____

Billing Address _____ Phone # _____

City, State _____ Zip Code _____

Email _____

Card Details **(please check one):**

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder's Name _____

Credit Card Number _____

Expiration Date _____ /_____

CVV Code _____

Zip Code _____

I authorize the above-named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above and is valid for one (1) time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

SIGNATURE _____ DATE _____
(cardholder)

*__Once payment clears card number will be obscured for security__

PLEASE FAX THIS COMPLETED FORM TO 1-440-835-5786