

LABORATORY SERVICE REQUEST (LSR) – Microbial Enumeration and Specified Organisms USP 60, 61, 62

CLIENT INFORMATION		
Instructions: Submit the form along with sample(s). Initiation of sample analysis will be delayed if form is not complete.		
PBL Quote Number:	PO Number:	<input type="checkbox"/> Credit Card to be used for payment
Sponsor (send report to):	Invoice To:	<input type="checkbox"/> Check box if same as sponsor
Contact Name:	AP Contact Name:	
Company Name:	Company Name:	
Address:	Address:	
City/State/Zip:	City/State/Zip:	
Country:	Country:	
Phone:	Invoice To Email:	
Email:	AP Email:	

SERVICE INFORMATION		
Regulatory Treatment:	<input type="checkbox"/> Non-regulatory <input type="checkbox"/> cGMP <input type="checkbox"/> GLP	Rush Service (will incur a surcharge): <input type="checkbox"/> YES <input type="checkbox"/> NO
Suitability (required by GMP regulations):		
<input type="checkbox"/> Suitability Completed* <input type="checkbox"/> Suitability Declined (please specify testing parameters in the Special Instructions) <input type="checkbox"/> Suitability to be conducted by Pacific BioLabs. Method: <input type="checkbox"/> Pour Plate <input type="checkbox"/> Membrane Filtration <input type="checkbox"/> USP 61 <input type="checkbox"/> Aerobic Plate Count – Specification: <input type="checkbox"/> Yeast and Mold Count – Specification: <input type="checkbox"/> USP 2021 <input type="checkbox"/> Aerobic Plate Count – Specification: <input type="checkbox"/> Yeast and Mold Count – Specification: <input type="checkbox"/> USP 62 <input type="checkbox"/> Salmonella <input type="checkbox"/> E. coli <input type="checkbox"/> S. aureus <input type="checkbox"/> P. aeruginosa <input type="checkbox"/> Clostridia <input type="checkbox"/> Candida <input type="checkbox"/> Bile Tolerant Negative Bacteria <input type="checkbox"/> Other: <input type="checkbox"/> USP 2022 <input type="checkbox"/> Salmonella <input type="checkbox"/> E. coli <input type="checkbox"/> S. aureus <input type="checkbox"/> P. aeruginosa <input type="checkbox"/> Clostridia <input type="checkbox"/> Candida <input type="checkbox"/> Bile Tolerant Negative Bacteria <input type="checkbox"/> Other: <input type="checkbox"/> USP 60 <input type="checkbox"/> Burkholderia cepacia complex		

SAMPLE INFORMATION		
Sample 1 Identification Please use the exact wording you want to appear in the final report.		Quantity of Samples Submitted Please indicate the number of units, volume, and/or weight of samples.
Lot Number: Other Identifier: Physical Description: <input type="checkbox"/> Device <input type="checkbox"/> Solid <input type="checkbox"/> Liquid <input type="checkbox"/> Powder <input type="checkbox"/> Gel <input type="checkbox"/> Other: Controlled Substance: <input type="checkbox"/> No <input type="checkbox"/> Yes Schedule: NDC #: Concentration: Hazardous: <input type="checkbox"/> NOT Hazardous <input type="checkbox"/> Reactive <input type="checkbox"/> Biohazard <input type="checkbox"/> Toxic <input type="checkbox"/> Other: *Suitability - PBL Report Number: Guideline Number: Method: <input type="checkbox"/> Pour Plate <input type="checkbox"/> Membrane Filtration		
Sample 2 Identification Please use the exact wording you want to appear in the final report.		Quantity of Samples Submitted Please indicate the number of units, volume, and/or weight of samples.
Lot Number: Other Identifier: Physical Description: <input type="checkbox"/> Device <input type="checkbox"/> Solid <input type="checkbox"/> Liquid <input type="checkbox"/> Powder <input type="checkbox"/> Gel <input type="checkbox"/> Other: Controlled Substance: <input type="checkbox"/> No <input type="checkbox"/> Yes Schedule: NDC #: Concentration: Hazardous: <input type="checkbox"/> NOT Hazardous <input type="checkbox"/> Reactive <input type="checkbox"/> Biohazard <input type="checkbox"/> Toxic <input type="checkbox"/> Other: *Suitability - PBL Report Number: Guideline Number: Method: <input type="checkbox"/> Pour Plate <input type="checkbox"/> Membrane Filtration		

Sample 3 Identification Please use the exact wording you want to appear in the final report.		Quantity of Samples Submitted Please indicate the number of units, volume, and/or weight of samples.
Lot Number:	Part Number:	
Other Identifier:	Expiration Date:	
Physical Description: <input type="checkbox"/> Device <input type="checkbox"/> Solid <input type="checkbox"/> Liquid <input type="checkbox"/> Powder <input type="checkbox"/> Gel <input type="checkbox"/> Other:		
Controlled Substance: <input type="checkbox"/> No <input type="checkbox"/> Yes	Schedule:	NDC #:
Hazardous: <input type="checkbox"/> NOT Hazardous <input type="checkbox"/> Reactive <input type="checkbox"/> Biohazard <input type="checkbox"/> Toxic <input type="checkbox"/> Other:		
*Suitability - PBL Report Number:	Guideline Number:	Method: <input type="checkbox"/> Pour Plate <input type="checkbox"/> Membrane Filtration

Storage Condition	Sample Disposition
<input type="checkbox"/> Room Temperature <input type="checkbox"/> 2 to 8C <input type="checkbox"/> -10 to -25C <input type="checkbox"/> -60 to -90C	<p><i>Samples will be discarded per PBL SOP unless otherwise indicated.</i></p> <input type="checkbox"/> Return UNTESTED Samples to Client <input type="checkbox"/> Return TESTED Samples to Client (must be preapproved by PBL) <i>If return address is different than Client address above, indicate address in Special Instructions below.</i> Carrier: Account: Dispose in: <input type="checkbox"/> municipal waste <input type="checkbox"/> hazardous waste

TESTING REQUIRED					
Harmonized Pharmacopeia – Microbial Enumeration and Specified Microorganisms					
Route of Administration:					
<input type="checkbox"/> Nonaqueous oral preparation	<input type="checkbox"/> Aqueous oral preparation	<input type="checkbox"/> Rectal use	<input type="checkbox"/> Oromucosal use	<input type="checkbox"/> Gingival use	
<input type="checkbox"/> Cutaneous use	<input type="checkbox"/> Nasal use	<input type="checkbox"/> Auricular use	<input type="checkbox"/> Vaginal use	<input type="checkbox"/> Inhalation use	<input type="checkbox"/> Transdermal patches
<input type="checkbox"/> Other:					

Routine Test		
<input type="checkbox"/> USP 61	<input type="checkbox"/> Aerobic Plate Count – Specification:	<input type="checkbox"/> Yeast and Mold Count – Specification:
<input type="checkbox"/> USP 2021	<input type="checkbox"/> Aerobic Plate Count – Specification:	<input type="checkbox"/> Yeast and Mold Count – Specification:
<input type="checkbox"/> USP 62	<input type="checkbox"/> Salmonella <input type="checkbox"/> E. coli <input type="checkbox"/> S. aureus <input type="checkbox"/> P. aeruginosa <input type="checkbox"/> Clostridia <input type="checkbox"/> Candida <input type="checkbox"/> Bile Tolerant Negative Bacteria <input type="checkbox"/> Other:	<input type="checkbox"/> Yeast and Mold Count – Specification:
<input type="checkbox"/> USP 2022	<input type="checkbox"/> Salmonella <input type="checkbox"/> E. coli <input type="checkbox"/> S. aureus <input type="checkbox"/> P. aeruginosa <input type="checkbox"/> Clostridia <input type="checkbox"/> Candida <input type="checkbox"/> Bile Tolerant Negative Bacteria <input type="checkbox"/> Other:	<input type="checkbox"/> Yeast and Mold Count – Specification:
<input type="checkbox"/> USP 60	<input type="checkbox"/> Burkholderia cepacia complex	<input type="checkbox"/> Yeast and Mold Count – Specification:

OTHER TESTS/SPECIAL INSTRUCTIONS	
<p><i>Note that samples will be reported separately per lot unless otherwise indicated.</i></p>	

TESTING AUTHORIZED BY (please sign):

(Signature and date, or electronic signature, is required for testing to begin; unsigned LSR forms will not be processed)

DATE: