



San Diego County Public Health Laboratory

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CLIA# 05D0060808

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Test Requisition Form

Patient Information <small>(*) denotes required information</small>			Submitter Information <small>NEW submitters are required to complete a Client Agreement Form before submitting specimen(s).</small>	
*Last Name	*First Name	Middle Name	*Ordering Physician	*National Provider ID (NPI)
*DOB	*Pregnancy Status	*Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M/F <input type="checkbox"/> F/M	<small>FIRST NAME LAST NAME</small> The physician or alternate contact completing this form confirms that they are compliant to the HIPPA Privacy Rule (45 CFR Parts 160 and 164) and that the fax number listed is a secure line to send test results.	<small>Please use the link below to find your physician's NPI: https://npiregistry.cms.hhs.gov/search</small>
*Address			*Facility Name	
*City, State, Zip			*Address	
*Phone #	MRN/ID#		*Phone	
*Race	American Indian/ Alaska Native Asian Pacific Islander Black/African American White Unknown Decline		Email	
*Ethnicity	Hispanic/ Latino Not Hispanic/ Latino Unknown Decline		*Alternate Contact <small>(ie. PHN/CDI/Epi)</small>	
For More Information on Extended Race and Ethnicity Click Here .			Clinical Information <small>(ie. date of onset/exposure, travel history, previous lab results)</small>	
Extended Race				
Extended Ethnicity				

Specimen Information

SUBMIT ONE TEST REQUISITION FORM PER SPECIMEN SOURCE

Collection Information	*Specimen Source					
*Date	<input type="checkbox"/> Blood	<input type="checkbox"/> Urethra	<input type="checkbox"/> Stool	<input type="checkbox"/> BAL	<input type="checkbox"/> Nasal	<input type="checkbox"/> Aspirate <small>(specify type):</small>
Time	<input type="checkbox"/> Serum	<input type="checkbox"/> Vaginal	<input type="checkbox"/> Rectal	<input type="checkbox"/> Nasopharynx	<input type="checkbox"/> CSF	<input type="checkbox"/> Body fluid <small>(specify type):</small>
Collected By	<input type="checkbox"/> Plasma	<input type="checkbox"/> Vaginal <small>(self collected)</small>	<input type="checkbox"/> Throat	<input type="checkbox"/> Buccal	<input type="checkbox"/> Tissue, Skin, Nail <small>(specify location):</small>	
Collection series #: ___ of ___	Urine	<input type="checkbox"/> Cervix	<input type="checkbox"/> Sputum <input type="checkbox"/> Induced	<input type="checkbox"/> Oropharynx	<input type="checkbox"/> Other <small>(specify):</small>	

*Test(s) Requested

Bacteriology	Parasitology	Molecular
<input type="checkbox"/> Aerobic Bacterial Culture	<input type="checkbox"/> Ova and Parasite Exam	<input type="checkbox"/> Chlamydia/Gonorrhea NAAT
<input type="checkbox"/> Aerobic Bacterial Identification <small>(*Attach worksheet/results)</small>	<input type="checkbox"/> Cryptosporidium DFA <input type="checkbox"/> Giardia DFA	<input type="checkbox"/> Trichomonas NAAT
<input type="checkbox"/> N. gonorrhoeae Culture GC Smear	<input type="checkbox"/> Malaria Confirmation	<input type="checkbox"/> HIV-1 Viral Load
<input type="checkbox"/> Enteric Pathogens ID <small>(specify organism):</small> <small>(*Attach worksheet/results)</small>	<input type="checkbox"/> Blood Parasite Identification	<input type="checkbox"/> HSV 1/2 PCR
<input type="checkbox"/> Enteric Pathogens Culture <small>(specify organism):</small>	<input type="checkbox"/> Coccidian Identification <small>(Cyclospora sp. and Isospora sp.)</small>	<input type="checkbox"/> 2019-nCoV <input type="checkbox"/> HCW <input type="checkbox"/> Resident <input type="checkbox"/> Other
<input type="checkbox"/> Rule Out <small>(specify organism):</small> <small>(*Attach worksheet/results)</small>	<input type="checkbox"/> Send Out <small>(specify test):</small>	<input type="checkbox"/> COVID-19-WGS Ct Value: <small>(*Enter Ct value of specimen)</small>
	Serology	Molecular*
	<input type="checkbox"/> SARS-CoV-2 IgG	<input type="checkbox"/> Hepatitis A PCR <small>(pre-approved only)</small> ¹
Mycobacteriology	<input type="checkbox"/> HIV- 1/2 Ag/Ab Reflex Panel	<input type="checkbox"/> Influenza PCR Previous test results <input type="checkbox"/> A <input type="checkbox"/> B
<input type="checkbox"/> AFB Smear. Culture. Susceptibility	<input type="checkbox"/> Syphilis Reflex Panel <small>(reverse algorithm)</small>	<input type="checkbox"/> Outpatient <input type="checkbox"/> Hospitalized <input type="checkbox"/> ICU
<input type="checkbox"/> MTB Complex Susceptibility Only	<input type="checkbox"/> QuantiFERON-TB <input type="checkbox"/> *Not Incubated	<input type="checkbox"/> Outbreak <input type="checkbox"/> Inmate <input type="checkbox"/> Fatal
<input type="checkbox"/> GeneXpert MTB/RIF PCR	<input type="checkbox"/> *Incubated Time in/out: _____/_____	<input type="checkbox"/> Outbreak case#
<input type="checkbox"/> MTB complex Isolate (Title 17) <small>(*Attach worksheet/results)</small>	<input type="checkbox"/> Hepatitis B Core Ab Total Reflex Panel	<input type="checkbox"/> Mumps PCR <small>(pre-approved only)</small> ²
<input type="checkbox"/> Other Test(s) <small>Consult with Lab</small>	<input type="checkbox"/> Hepatitis C Ab Reflex Panel	<input type="checkbox"/> Measles PCR <small>(pre-approved only)</small> ²
	<input type="checkbox"/> Measles IgG	<input type="checkbox"/> Norovirus PCR <small>(pre-approved only)</small> ¹
		<input type="checkbox"/> Mpox Rule Out Clade I <small>(pre-approved only)</small> ¹

1-This test must be approved by the San Diego County Epidemiology Program, please call 619-692-8499. 2- This test must be approved by the San Diego County Immunization Program, please call 866-358-2966 option 5. Tests may be subject to incur costs to the submitter per the board approved fee schedule. Board approved fees can be found on the San Diego County Public Health Laboratory website.

*Specimen(s) tested at San Diego County Public Health Modular Laboratory located at 5587 Overland Avenue, San Diego, CA 92123 CLIA# 05D2274872