CITY AND COUNTY OF SAN FRANCISCO
PUBLIC HEALTH LABORATORY
101 Grove Street, Room 419
San Francisco, CA 94102
Tel: (415) 554-2800 Fax: (415) 431-0651
CLIA ID # 05D0643643

THIS SPACE IS FOR LABORATORY USE ONLY

BACTERIOLOGY / PARASITOLOGY SUBMISSION FORM

(FOR MYCOBACTERIOLOGY, USE THE GENERAL REQUEST FORM)

ALL FIELDS ARE REQUIRED – PLEASE TYPE OR PRINT LEGIBLY

Patient information:

Patient's Name: _____, _____ _____ **Medical Record #:** _____
Last, First (Middle)

Gender: _____ **Date of Birth:** _____ / _____ / _____

Patient's Address: _____ Phone: _____

City / State: _____ Zip Code: _____

Submitting Clinic Information:

Submitting Laboratory/Clinic: _____

Requesting Clinician: _____
(REQUIRED)

Submitter's identification of organism:

COLLECTION DATE: _____

Specimen source (check one):

☐ Blood ☐ Urine ☐ Stool ☐ CSF

☐ Wound, location: _____

☐ Tissue, type: _____

☐ Other, specify: _____

☐ Blood smear (for malaria): ☐ Thin ☐Thick

TEST REQUESTED:

BACTERIOLOGY
☐ Enteric Culture for Identification / Title 17 Submission
☐ Special Bacteriology Culture for Identification**
☐ Clearance for: _____
☐ blaKPC / blaNDM PCR
☐ Other: _____

PARASITOLOGY
☐ Blood Smear (e.g. Malaria)**
☐ Clearance for: _____

**Additional information required (see below)

SUBMITTER'S LABORATORY FINDINGS

FOR ALL CULTURES FOR IDENTIFICATION:

Cultures made from original clinical sample were: ☐ Pure ☐ Mixed
If mixed, list other organisms present: _____
Indicate colony count where applicable (e.g. urine): _____
Number of times organism isolated from the patient: _____
Medium(s) on which primary growth was obtained: _____
Were stained smears or other preparations made directly from clinical material?
☐ Yes ☐ No
If yes, was this organism seen? ☐ Yes ☐ No
Medium on which organism is being submitted: _____
Date inoculated: _____
Conditions prior to mailing: Temp: _____ Atmosphere: _____ Length: _____

FOR SPECIAL BACTERIOLOGY ONLY:
Required: Brief but complete case history, therapy, outcome (attach additional forms if necessary):

FOR MALARIA ONLY (*Required*):
Physician's Name: _____
Physician's Phone #: _____
Date on onset: _____
Travel history, symptoms, treatment:

Submitter's laboratory findings (biochemical results, Gram stain results, agglutination results; please be comprehensive—attach additional forms as necessary):

Comments: _____
_____

For instructions on collecting and storing specimens, along with electronic copies of this form, please visit our website at: www.sfcdcp.org/phl.