CITY AND COUNTY OF SAN FRANCISCO
PUBLIC HEALTH LABORATORY
101 Grove Street, Room 419
San Francisco, CA 94102
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Mark Pandori, PhD., Lab Director
CLIA ID # 05D0643643

For Laboratory Use Only:

______________________ Laboratory Number

__________________ Date/Time Received

PLEASE ATTACH PRE-PRINTED LABEL or PRINT CLEARLY

Patient's Name: ______________________________________ Gender: ____ DOB: ____________ Race/Ethnicity: ____________
Last, First

Address: ____ Phone: ______________________

City / State: ____ Zip Code: ______________________

Submitted By: _____________________________________ Requesting Clinician: ___________________________________
(Clinic)
Medical Record #: __________________________ **Medi-Cal/HAP #:** ____________________ V-Code #: __________________

Bill To: ☐ Submitter ☐ Medi-Cal ☐ Family Planning ☐ Private Pay ☐ Indigent

CHECK BOTH SOURCE AND TEST REQUESTED; INDICATE DATE COLLECTED

SPECIMEN SOURCE: **DATE SPECIMEN TAKEN:** __________________

☐ Blood	☐ Urine	☐ Rectal	☐ Throat	☐ Rash/Lesion	☐ Culture
☐ Serum	☐ Cervix	☐ Feces	☐ Sputum	☐ CSF	☐ Slide
☐ Plasma	☐ Urethral	☐ Genital	☐ Nasopharyngeal	☐ Oral Fluid	☐ Other: ______________
	☐ Vaginal				

BACTERIOLOGY

- ☐ Gonorrhea Screen
- ☐ Enteric Screen
- ☐ Special Bacteriology Culture
- ☐ Clearance for: _______________

PARASITOLOGY

- ☐ Ova and Parasites
- ☐ Clearance for: _______________
- ☐ Blood Smear (e.g. Malaria)**
- ☐ Cryptosporidia
- ☐ Cyclospora
- ☐ Other: _____________________

MYCOBACTERIA

- ☐ Acid Fast Smear
- ☐ Specimen for Isolation
- ☐ Culture for Identification
- ☐ TB Susceptibility
- ☐ Direct Amplification Test

MYCOBACTERIA SEROLOGY

☐ Quantiferon (TB blood test)*

For Quantiferon, please indicate Time of Collection: _____________

Incubation Start Time: _____________

Incubation Stop Time: _____________

A reason for Quantiferon testing MUST be checked:

- ☐ Immunocompromised
- ☐ TB suspect
- ☐ Foreign-born
- ☐ Contact to TB
- ☐ Homeless
- ☐ Diabetes
- ☐ IVDU
- ☐ Renal failure
- ☐ Program clearance
- ☐ School clearance (US born)
- ☐ Other _______________________

HIV VIRAL LOAD (RT-PCR)*

☐ Time Collected: ______________

CHLAMYDIA AND GONORRHEA

- ☐ Chlamydia
- ☐ Gonorrhea

A reason for CT/GC testing MUST be checked:

- ☐ Females age ≤ 25
- ☐ MSM/TG
- ☐ Prior CT/GC Infection
- ☐ IUD insertion
- ☐ Diagnostic/Symptomatic
- ☐ Study Site
- ☐ Contact to STD
- ☐ STD Control
- ☐ Pregnant (1st & 3rd trimester)

SEROLOGY

- ☐ Syphilis - Screen
- ☐ Herpes Simplex-2
- ☐ Syphilis - VDRL
- ☐ Other: __________
- ☐ Syphilis - TPPA
- ☐ HCV Screen - Time Collected: __________

VIROLOGY

- ☐ Herpes PCR
- ☐ Other: _____________________

Comment: ____

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*** Specimens have time limitations for submission. Contact laboratory for details.**
****Travel History Required**