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
Director: Godfred Masinde, PhD, HCLD (ABB)

THIS SPACE IS FOR LABORATORY USE ONLY

ALL FIELDS IN BOLD ARE REQUIRED – SPECIMENS WITH INCOMPLETE FORMS WILL BE REJECTED

PLEASE TYPE OR PRINT LEGIBLY, OR AFFIX PREPRINTED LABEL HERE

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

Medical Record # (if present): _____ Address: _____ Zip Code: _____

Gender: _____ **Date of Birth:** _____ / _____ / _____ City / State: _____ Phone: _____

Submitting Clinic: _____
(**REQUIRED**)

Requesting Clinician: _____
(**REQUIRED**) **Full Name** (Last, First)
PRINT LEGIBLY, OR SPECIMEN WILL BE REJECTED

CHN # (**required** for providers who have a SF CHN #)

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

Comments:
_____
_____

INSURANCE

PLEASE CHECK ONE: ☐ **Medi-Cal** ☐ **Family PACT** ☐ **S.F. Health Plan** ☐ **Blue Shield**
☐ **Blue Cross** ☐ **Uninsured** ☐ **Other:** _____ ☐ **Not provided by patient**

If patient provided insurance information:

Patient Insurance I.D. #: _____ **Diagnosis Code(s):** _____

COLLECTION DATE: _____

Specimen source (check one):
☐ Blood ☐ Plasma ☐ Clinician-Collected Rectal ☐ Self-Collected Rectal ☐ Urethral ☐ Genital ☐ Clinician-Collected Throat ☐ Self-Collected Throat ☐ Clinician-Collected Vaginal ☐ Self-Collected Vaginal ☐ Urine ☐ Rash/Lesion ☐ Sputum ☐ Oral Fluid ☐ Serum ☐ Other: _____

TEST REQUESTED (PLEASE USE ONE FORM PER SPECIMEN)

HIV SCREENING
Rapid Test (RT) result:
☐(-) ☐(+) ☐(+,+) ☐(+,-)
☐ RT not performed
Collection time: _____
☐ Pooled RNA (RT Negative)
☐ HIV Ab/Ag Screen (CMIA)
☐ Individual RNA
☐ RT Positive Confirmation

HIV VIRAL LOAD (RT-PCR) *
☐ Time collected: _____

HEPATITIS SCREENING
Collection time: _____

☐ Hepatitis C (HCV) Antibody Screen*
☐ Hepatitis C Rapid Test Positive Confirmation*
HCV Rapid Test (RT) result:
☐(-) ☐(+)
☐ Hepatitis B Screening Panel

CHLAMYDIA / GONORRHEA TMA
(Molecular Detection / NAAT)
☐ Chlamydia TMA
☐ Gonorrhea TMA

***TRICHOMONAS VAGINALIS* TMA**
(Molecular Detection / NAAT)
(Endocervical, Vaginal swab and Urine sources only)
☐ *Trichomonas vaginalis* TMA

***Mycoplasma genitalium* TMA**
(Molecular Detection / NAAT)
(Urine, Vaginal, Endocervical, Urethral, Penile meatal sources only)
☐ *Mycoplasma genitalium* TMA

***Herpes Simplex Virus 1/2* TMA**
(Molecular Detection / NAAT)
(Clinician collected Anogenital, Throat, Rash/Lesion and Oral swabs only)
☐ *Herpes Simplex Virus 1/2* TMA

SEROLOGY
☐ Syphilis – Screen (RPR)
☐ Syphilis – TPPA
☐ Herpes Simplex 2 EIA

BACTERIOLOGY
☐ Gonorrhea Culture and AST (**for select submitters**)

MYCOBACTERIA SEROLOGY
☐ QuantiFERON (TB blood test) *
Collection time ***required***: _____
Incubation start date: _____
Incubation start time: _____
Incubation stop time: _____

MYCOBACTERIOLOGY
☐ Acid Fast Smear
☐ Specimen for Isolation
☐ Culture for Identification
Submitter's ID: _____
☐ TB Drug Susceptibility
☐ TB Molecular Detection (PCR)

MOLECULAR DIAGNOSTICS
☐ Lymphogranuloma venereum (LGV) PCR
☐ Influenza PCR
☐ Measles PCR
☐ Mumps PCR
☐ Mpox PCR
☐ Respiratory Panel PCR
☐ Gastrointestinal Panel PCR
☐ Norovirus PCR
☐ CRE PCR
☐ Other: _____

***** Specimens have time limitations for submission. See our webpage for details.