

Date Received: _____

**Long Beach Department of
Health & Human Services Public Health Laboratory**
2525 Grand Ave, Room 260
Long Beach, CA 90815
Tel: (562) 570-4080 Fax: (562) 540-4070

Lydia Mikhail, DrPH, HCLD, MBA, ME L
Interim Laboratory Director
CLIA: 05D0688088
ELAP: 2368

LABORATORY TEST REQUEST FORM

Patient Information (REQUIRED):

Patient's Name (Last, First, Middle Initial)

Street Address:

City: _____ State: _____ ZIP: _____

DOB: _____

Gender: M F M-F F-M Other: _____

Pregnant: yes No Unknown

Ethnicity: W B H A/PI Other: _____

Patient phone number:

Submitter Information (REQUIRED):

Address: _____

Phone Number: _____

Requesting Physician/Clinician & NPI #:

Additional Patient Information

Patient medical record number:

Patient History:

Diagnosis: _____

Onset Date: _____

SPECIMEN INFORMATION COLLECTION (REQUIRED)

Date Collected (MM/DD/YYYY): _____

Time Collected (HR:MIN): _____ AM PM

Collected by: _____

SPECIMEN SOURCE (REQUIRED)

<input type="checkbox"/> Blood	<input type="checkbox"/> Ear	<input type="checkbox"/> Perineum	<input type="checkbox"/> Swube	<input type="checkbox"/> Vagina
<input type="checkbox"/> Bronchial Washing	<input type="checkbox"/> Eye	<input type="checkbox"/> Rectal Swab	<input type="checkbox"/> Throat	<input type="checkbox"/> Vesicle-swab
<input type="checkbox"/> Capillary	<input type="checkbox"/> Feces	<input type="checkbox"/> Serum	<input type="checkbox"/> Urethra	<input type="checkbox"/> Wound
<input type="checkbox"/> Cervix	<input type="checkbox"/> Nasopharyngeal Swab	<input type="checkbox"/> Sputum (induced)	<input type="checkbox"/> Urine (clean catch)	<input type="checkbox"/> Other (Please Specify):
<input type="checkbox"/> CSF	<input type="checkbox"/> Nasal Swab	<input type="checkbox"/> Sputum (regular)	<input type="checkbox"/> Urine (voided)	_____

COMPLETE FOR ALL BILLING TYPES AND ATTACH A COPY OF THE PATIENT'S PROOF OF INSURANCE:

Bill to: Submitter CHDP (DHCS 4073) Medicare MediCal State FP Other: _____
 Diagnosis Code: Primary _____ Secondary: _____

Please Indicate Test(s) Requested			
<p>BACTERIOLOGY</p> <p><input type="checkbox"/> Culture for ID, Aerobic</p> <p><input type="checkbox"/> Culture for ID, Anaerobic</p> <p><input type="checkbox"/> Culture for ID, Enterics</p> <p><input type="checkbox"/> Bordetella pertussis Culture</p> <p><input type="checkbox"/> Campylobacter Culture</p> <p><input type="checkbox"/> Legionella pneumophila</p> <p><input type="checkbox"/> Salmonella/Shigella Culture</p> <p><input type="checkbox"/> STEC Culture</p> <p><input type="checkbox"/> Stool Culture (CompleteEnterics)</p> <p><input type="checkbox"/> Throat Culture</p> <p><input type="checkbox"/> Urine Culture</p> <p>VIROLOGY:</p> <p><input type="checkbox"/> Rabies DFA</p>	<p>MOLECULAR</p> <p><input type="checkbox"/> Chikungunya PCR</p> <p><input type="checkbox"/> Chlamydia/GC NAAT</p> <p><input type="checkbox"/> Dengue PCR</p> <p><input type="checkbox"/> Influenza A&B PCR</p> <p><input type="checkbox"/> Measles PCR</p> <p><input type="checkbox"/> Norovirus PCR</p> <p><input type="checkbox"/> STEC PCR</p> <p><input type="checkbox"/> Flavivirus Detection by Triplex PCR</p> <p><input type="checkbox"/> Mumps PCR</p> <p><input type="checkbox"/> MPOX PCR</p> <p><input type="checkbox"/> Respiratory Pathogen PCR Panel</p> <p><input type="checkbox"/> SARS-CoV-2/FLU/RSV PCR</p>	<p>PARASITOLOGY</p> <p><input type="checkbox"/> Cryptosporidium/Giardia DFA</p> <p><input type="checkbox"/> Malaria/Blood Parasite ID</p> <p><input type="checkbox"/> Ova and Parasite</p> <p>MYCOBACTERIOLOGY</p> <p><input type="checkbox"/> AFB Culture & Sensitivity</p> <p><input type="checkbox"/> AF Culture for ID, Mycobacterium</p> <p><input type="checkbox"/> M. tb Culture for Title 17 _____ Reportable Only</p> <p><input type="checkbox"/> MTB-RIF (NAAT)</p>	<p>OTHER TEST(S) REQUESTED: IF NOT ON LIST OR REFERRED OUT:</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>

Updated 4/30/26