LABORATORY TEST REQUEST FORM

DATE RECEIVED:

LONG BEACH DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH LABORATORY
2525 Grand Ave, Room 208
Long Beach, CA 90815
Tel: (562) 570-4080 Fax: (562) 570-4070

Lydia Mikhail, DrPH, HCLD, MBA, MEL
Interim Laboratory Director

CLIA: 05D0688088
ELAP: 2368

PATIENT INFORMATION (REQUIRED)				SUBMITTER INFORMATION (REQUIRED)
PATIENT'S NAME (Last, First, Middle Initial)				SUBMITTER
DOB	GENDER ☐M ☐F ☐M-F ☐F-M ☐OTHER	PREGNANT ☐YES ☐NO ☐UNKNOWN	ETHNICITY ☐W ☐B ☐H ☐A/PI ☐OTHER	SUBMITTER ADDRESS
STREET ADDRESS				SUBMITTER PHONE NUMBER
CITY	STATE	ZIP		REQUESTING PHYSICIAN/CLINICIAN & NPI #

SPECIMEN COLLECTION INFORMATION (REQUIRED)	ADDITIONAL PATIENT INFORMATION
DATE COLLECTED (MM/DD/YYYY)	PATIENT MEDICAL RECORD NUMBER
TIME COLLECTED (HR:MIN) ☐AM ☐PM	DIAGNOSIS
COLLECTED BY	PATIENT HISTORY (Please attach a separate form)

SPECIMEN SOURCE (REQUIRED)

☐Blood (Whole)	☐Ear	☐Perineum	☐Swube	☐Venous
☐Bronchial Washing	☐Eye	☐Rectal Swab	☐Throat	☐Vagina
☐Capillary	☐Feces	☐Serum	☐Urethra	☐Wound
☐Cervix	☐Nasopharyngeal Swab	☐Sputum (induced)	☐Urine (clean catch)	☐Other (Please Specify)
☐CSF	☐Plasma	☐Sputum (regular)	☐Urine (voided)	_____

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

Bill to: ☐Submitter ☐CHDP (DHCS 4073) ☐Medicare ☐MediCal ☐State FP ☐Other _____

Diagnosis Codes: ☐Primary _____ ☐Secondary _____

PLEASE INDICATE TEST(S) REQUESTED

BACTERIOLOGY
- ☐Culture for ID, Aerobic
- ☐Culture for ID, Anaerobic Culture for ID, Enterics
- ☐*Bordetella pertussis* Culture
- ☐Campylobacter Culture
- ☐Legionella pneumophila
- ☐Salmonella/Shigella Culture STEC Culture
- ☐Stool Culture (Complete
- ☐Enterics) Throat Culture
- Urine Culture

MOLECULAR
- ☐Chikungunya PCR
- ☐Chlamydia / GC NAAT
- ☐Dengue PCR Enterovirus
- ☐PCR Influenza A & B
- ☐PCR Measles PCR
- ☐Norovirus PCR
- ☐STEC PCR
- ☐Zika PCR

MYCOBACTERIOLOGY
- ☐AFB Culture and Sensitivity
- ☐AFB DNA Probe
- ☐Culture for ID, Mycobacterium
- ☐M. tb Culture for Title 17 Reportable Only

PARASITOLOGY
- ☐Cryptosporidium/Giardia DFA
- ☐Malaria/Blood Parasite ID
- ☐Ova and Parasite

SEROLOGY
- ☐WNV & IgM
- ☐Zika IgM

VIROLOGY
- ☐Rabies DFA

OTHER TEST(S) REQUESTED (IF NOT ON LIST)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

WHITE – Laboratory GOLDENROD -- Submitter