COUNTY OF SAN DIEGO
HHSA
HEALTH AND HUMAN SERVICES AGENCY

**San Diego County Public Health Laboratory**
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PUBLIC HEALTH LAB USE ONLY

# Test Requisition Form

(*) denotes required information

| Patient Information | | Submitter Information | |
|---|---|---|---|
| *Name (Last, First) | | *Ordering Physician | |
| | | *NPI# | |
| *DOB | *Gender ☐ M ☐F ☐M/F ☐F/M | *Facility | |
| MRN/ID# | | Address | |
| Race (Required for Detention Facilities) ☐ White ☐Black/Afr Amer ☐AmerInd/Alaskan ☐ Asian Pacific Islander ☐ Other ☐ Unknown ☐Decline | | City, State, Zip | |
| Ethnicity (Required for Detention Facilities) ☐Hispanic/Latino ☐ Not Hispanic/Latino ☐Unknown ☐Decline | | *Phone | *Fax |
| Clinical Information (ie. date of onset/exposure, travel history, pregnant, previous lab results) | | *Alternate contact (ie. PHN/CDI/Epi) | *Phone and Fax |

*The physician or alternate contact completing this form confirms that they are compliant to the HIPPA Privacy Rule (45 CFR Parts 160 and 164) and that the fax number listed is a secure line to send test results.

# Specimen Information

**SUBMIT ONE TEST REQUISITION FORM PER SPECIMEN SOURCE**

| Collection Information | *Specimen Source | | | | |
|---|---|---|---|---|---|
| *Date | ☐Blood,whole | ☐ Urethra | ☐ Stool | ☐ BAL | ☐ Aspirate (specify type): |
| Time | ☐Serum | ☐ Vaginal | ☐ Rectal | ☐ Nasopharynx | ☐ Body fluid (specify type): |
| Collected By | ☐Plasma | ☐ Vaginal (self collected) | ☐ Throat | ☐ CSF | ☐ Tissue, Skin, Nail (specify location): |
| Collection series #:__of __ | ☐Urine | ☐ Cervix | ☐ Sputum ☐ Induced | ☐ Oral Fluid | ☐ Other (specify): |

# *Test(s) Requested

| Bacteriology | Parasitology | Molecular |
|---|---|---|
| ☐ Aerobic Bacterial Culture | ☐ Blood Smear/Parasites Exam | ☐ Chlamydia/Gonorrhea NAAT |
| ☐ Aerobic Bacterial Identification (*Please attach worksheet/results) | ☐ Cryptosporidium/Giardia DFA | ☐ Enterovirus PCR |
| ☐ N. gonorrhoeae Gram Stain | ☐ Ova and Parasite Exam | ☐ HIV-1 Viral Load |
| ☐ N. gonorrhoeae Culture | ☐ Malaria Confirmation | ☐ HSV 1/2 PCR |
| ☐ Enteric Pathogens ID (specify organism): (*Please attach worksheet/results) | ☐ Worm Identification | ☐ Influenza PCR<br>☐ **Outbreak (OB) Associated**<br>☐ **Intensive Care Unit (ICU)**<br>☐ **Fatal Case, Date of Death** _____ |
| ☐ Enteric Pathogens Culture (specify organism): | **Serology** | |
| ☐ Syphilis Darkfield | ☐ HIV- 1/2 Ag/Ab Reflex Panel | ☐Norovirus PCR (pre-approved only)[2] |
| ☐ Rule Out (specify organism): (*Please attach worksheet/results) | ☐ Measles IgM (pre-approved only)[3] | ☐ Measles PCR (pre-approved only)[3] |
| **Mycobacteriology** | ☐ Measles IgG (pre-approved only)[3] | ☐ Trichomonas NAAT |
| ☐ AFB Smear, Culture, Susceptibility | ☐ Syphilis CIA[1] | ☐ Zika Panel for NAAT and IgM (**serum only**) |
| ☐ MTB Complex Susceptibility Only | ☐ Quantiferon-TB ☐*Not Incubated ☐*Incubated Time in/out:_____/_____ | ☐ Zika NAAT (**urine only**) |
| ☐ GeneXpert MTB/RIF PCR | ☐ Send Out (specify test): | ☐ Hepatitis A PCR (Epidemiological Purposes Only) |
| ☐ MTB complex Isolate (*Please attach worksheet/results) | | ☐ Other Test(s) **consult with lab:** |

**1-This test order will automatically reflex using the reverse algorithm for confirmation, 2-This test must be approved by the San Diego County Epidemiology Program, please call 619-692-8499. 3- This test must be approved by the San Diego County Immunization Program, please call 866-358-2966 option 5.**