



# San Diego County Public Health Laboratory

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CLIA# 05D2324555

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PUBLIC HEALTH LAB USE ONLY

## Test Requisition Form

Patient Information (* denotes required information)			Submitter Information New submitters must complete a <b>Client Agreement Form</b> . Results will <u>not</u> be released until the form is submitted.	
*Last Name	*First Name	Middle Name	FIRST NAME LAST NAME *Ordering Physician *National Provider ID (NPI)	
*DOB	*Pregnancy Status	*Gender Male Female Transgender M/F Decline Transgender F/M Unknown		
*Address			*Facility Name	
*City, State, Zip			*Address	
*Phone	MRN/ID#		*Phone	Email
*Race American Indian/ Alaska Native Asian Pacific Islander Black/African American White Unknown Decline			*Alternate Contact (ie. PHN/CDI/Epi)	
*Ethnicity Hispanic/ Latino Not Hispanic/ Latino Unknown Decline			Original Submitter (if applicable)	
For More Information on Extended Race and Ethnicity Click <a href="#">Here</a> . Extended Race Extended Ethnicity			Clinical Information (ie. date of onset/exposure, travel history, previous lab results) Case ID	

## Specimen Information

SUBMIT ONE TEST REQUISITION FORM PER SPECIMEN SOURCE

Collection Information	*Specimen Source					
*Date	<input type="checkbox"/> Blood	<input type="checkbox"/> Urethra	<input type="checkbox"/> Stool	<input type="checkbox"/> BAL	<input type="checkbox"/> Nasal	<input type="checkbox"/> Aspirate (specify type):
Time	<input type="checkbox"/> Serum	<input type="checkbox"/> Vaginal	<input type="checkbox"/> Rectal	<input type="checkbox"/> Nasopharynx	<input type="checkbox"/> CSF	<input type="checkbox"/> Body fluid (specify type):
Collected By	<input type="checkbox"/> Plasma	<input type="checkbox"/> Vaginal (self collected)	<input type="checkbox"/> Throat	<input type="checkbox"/> Buccal	<input type="checkbox"/> Tissue, Skin, Nail (specify location):	
Collection series #: ___ of ___	Urine	<input type="checkbox"/> Cervix	<input type="checkbox"/> Sputum <input type="checkbox"/> Induced	<input type="checkbox"/> Oropharynx	<input type="checkbox"/> Other (specify):	

## \*Test(s) Requested

Bacteriology	Parasitology	Molecular
<input type="checkbox"/> Aerobic Bacterial Culture	<input type="checkbox"/> Ova and Parasite Exam	<input type="checkbox"/> Chlamydia/Gonorrhea NAAT
<input type="checkbox"/> Aerobic Bacterial Identification (*Attach worksheet/results)	<input type="checkbox"/> Cryptosporidium DFA <input type="checkbox"/> Giardia DFA	<input type="checkbox"/> Trichomonas NAAT
<input type="checkbox"/> N. gonorrhoeae Culture GC Smear	<input type="checkbox"/> Malaria Confirmation	<input type="checkbox"/> HIV-1 Viral Load
<input type="checkbox"/> Enteric Pathogens ID (specify organism): (*Attach worksheet/results)	<input type="checkbox"/> Blood Parasite Identification	<input type="checkbox"/> HSV 1/2 PCR
<input type="checkbox"/> Enteric Pathogens Culture (specify organism):	<input type="checkbox"/> Coccidian Identification (Cyclospora sp. and Isospora sp.)	<input type="checkbox"/> Resp. Panel <input type="checkbox"/> HCW <input type="checkbox"/> Resident <input type="checkbox"/> Other
<input type="checkbox"/> Rule Out (specify organism): (*Attach worksheet/results)	<input type="checkbox"/> Send Out (specify test):	<input type="checkbox"/> COVID-19-WGS Ct Value: (*Enter Ct value of specimen)
	<b>Serology</b>	<input type="checkbox"/> Send Out (specify test):
	<input type="checkbox"/> SARS-CoV-2 IgG	<input type="checkbox"/> Hepatitis A PCR (pre-approved only) <sup>1</sup>
<b>Mycobacteriology</b>	<input type="checkbox"/> HIV- 1/2 Ag/Ab Reflex Panel	<input type="checkbox"/> Influenza PCR Previous test results <input type="checkbox"/> A <input type="checkbox"/> B
<input type="checkbox"/> AFB Smear. Culture. Susceptibility	<input type="checkbox"/> Syphilis Reflex Panel (reverse algorithm)	<input type="checkbox"/> Outpatient <input type="checkbox"/> Hospitalized <input type="checkbox"/> ICU
<input type="checkbox"/> MTB Complex Susceptibility Only	<input type="checkbox"/> QuantiFERON-TB <input type="checkbox"/> *Not Incubated <input type="checkbox"/> *Incubated Time in/out: ____/____	<input type="checkbox"/> Outbreak <input type="checkbox"/> Inmate <input type="checkbox"/> Fatal
<input type="checkbox"/> GeneXpert MTB/RIF PCR	<input type="checkbox"/> Hepatitis B Core Ab Total Reflex Panel	Outbreak case#
<input type="checkbox"/> MTB complex Isolate (Title 17) (*Attach worksheet/results)	<input type="checkbox"/> Hepatitis C Ab Reflex Panel	<input type="checkbox"/> Mumps PCR (pre-approved only) <sup>2</sup>
<input type="checkbox"/> Other Test(s) Consult with Lab	<input type="checkbox"/> Measles IgG	<input type="checkbox"/> Measles PCR (pre-approved only) <sup>2</sup>
		<input type="checkbox"/> Norovirus PCR (pre-approved only) <sup>1</sup>
		<input type="checkbox"/> Mpox Rule Out Clade I (pre-approved only) <sup>1</sup>
		<input type="checkbox"/> SDPHL Dengue PCR (pre-approved only) <sup>1</sup>

1-This test must be approved by the San Diego County Epidemiology Program, please call 619-692-8499. 2-This test must be approved by the San Diego County Immunization Program, please call 866-358-2966 option 5. Submitters may incur fees for testing, in accordance with the board-approved fee schedule available on the San Diego County Public Health Laboratory website.

Specimens received at the San Diego County Public Health Laboratory located at 5540 Overland Avenue, San Diego, CA 92123, may be tested at one of the following CLIA-certified facilities:

San Diego County Public Health Laboratory (NEW)  
5540 Overland Avenue, San Diego, CA 92123  
CLIA# 05D2324555

San Diego County Public Health Laboratory (COOP)  
5570 Overland Avenue, San Diego, CA 92123  
CLIA# 05D0060808

San Diego County Public Health Modular Laboratory  
5587 Overland Avenue, San Diego, CA 92123  
CLIA# 05D2274872

Effective 06/02/2025