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

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:
☐(-) ☐(+) ☐(+,+) ☐(+,-)

Collection time: _____

☐ Pooled RNA (RT Negative)
☐ HIV Ab/Ag Screen (CMIA)
☐ Individual RNA (Suspected Acute)
☐ Oral Fluid HIV
☐ RT Positive Confirmation

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

HEPATITIS C SCREENING
Collection time: _____

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

CHLAMYDIA / GONORRHEA TMA (Molecular Detection / NAAT)

☐ Chlamydia TMA
☐ Gonorrhea TMA

A reason for CT/GC testing MUST be checked:

☐ Females age ≤ 25
☐ Prior CT/GC Infection
☐ Diagnostic/Symptomatic
☐ Contact to STD
☐ Pregnant (1st & 3rd trimester)
☐ MSM/TG
☐ IUD insertion
☐ Study Site
☐ STD Control

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

BACTERIOLOGY
☐ Gonorrhea Culture (restricted to **City Clinic only**)

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
☐ Herpes PCR
☐ Lymphogranuloma venereum (LGV) PCR
☐ Influenza PCR
☐ Measles PCR

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