



**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: _____, _____ (Middle)
Last, First

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.sfcddcp.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: _____ Clinician-Collected Throat Urine
Specimen source (check one): Clinician-Collected Rectal Self-Collected Throat Rash/Lesion
 Blood Plasma Self-Collected Rectal Clinician-Collected Vaginal Sputum
 Oral Fluid Serum Urethral Genital Self-Collected Vaginal Other: _____

TEST REQUESTED (PLEASE USE ONE FORM PER SPECIMEN)

HIV SCREENING
Rapid Test (RT) result:
 (-) (+) (+,+) (+,-)
 RT not performed

Collection time: _____

 Pooled RNA (RT Negative)
 HIV Ab/Ag Screen (CMIA)
 Individual RNA
 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 MSM/TG
 Prior CT/GC Infection IUD insertion
 Diagnostic/Symptomatic Study Site
 Contact to STD STD Control
 Pregnant (1st & 3rd trimester)

TRICHOMONAS VAGINALIS TMA (Molecular Detection / NAAT)
(for vaginal swab and urine sources only)

 Trichomonas vaginalis TMA

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

BACTERIOLOGY
 Gonorrhea Culture and AST (for select submitters)

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
 Norovirus PCR
 Other: _____