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
Director: Godfred Masinde, PhD

THIS SPACE IS FOR LABORATORY USE ONLY

COVID-19 and INFLUENZA A+B TESTING REQUISITION FORM

Instructions:

- **ALL FIELDS ON THE FORM ARE FEDERALLY MANDATED. EVERY FIELD MUSTBE COMPLETED OR SPECIMEN WILL BE REJECTED**.
- Please type or print legibly.
- This form is intended for COVID-19 test requisitions only.
- Please include a printed copy of this form with the specimen submission.
- For electronic copies of this form, please visit our webpage at: https://www.sfcdcp.org/public-health-lab/forms-specimen-culture-submission/.

Additional Information:

- For guidance on specimen collection and storage, please refer to SFDPH's Clinical and Testing Guidance: https://www.sfcdcp.org/infectious-diseases-a-to-z/coronavirus-2019-novel-coronavirus/coronavirus-2019-information-for-healthcare-providers/
- Hospitals and large health systems are asked to provide transport of specimens to PHL between the hours of 8 AM and 8 PM Monday-Friday and 9 AM to 5 PM Saturday-Sunday. If you do not have the capacity to transport specimen, SFDPH can arrange for scheduled transport. Please contact the Communicable Disease Control Unit (CDCU) between the hours of 8 AM and 5 PM at (415) 554-2830 and follow the automated instructions to schedule transport.
- Testing guidelines are subject to change. Please refer to the latest advisories here: https://www.sfcdcp.org/health-alerts-emergencies/health-alerts/.

PLEASE COMPLETE REQUISITION FORM ON REVERSE SIDE. PLEASE ATTACH A COPY WITH THE SPECIMEN.

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TEST REQUESTED (PLEASE USE ONE FORM PER SPECIMEN): ☐ COVID-19 Qualitative RT-PCR Testing **ONLY**

☐ COVID-19 Qualitative RT-PCR Testing **AND** Influenza A+B RT-PCR Testing

Is the patient experiencing any of the following symptoms? ☐ Yes ☐ No ☐ Unknown **Date of symptom onset?** ____/_____/_____

- Fever or chills
- Cough
- Sore Throat
- Shortness of Breath
- Headache
- Diarrhea
- Muscle or body aches
- Fatigue
- Congestion or runny nose
- Loss of Small and Taste
- Nausea or vomiting

Is patient a resident of a congregate care setting? ☐ Yes ☐ No ☐ Unknown

Is the patient employed in healthcare? ☐ Yes ☐ No ☐ Unknown

Is the patient pregnant? ☐ Yes ☐ No ☐ Unknown

Has the patient been hospitalized? ☐ Yes ☐ No ☐ Unknown

Is the patient in the ICU? ☐ Yes ☐ No ☐ Unknown

IF PATIENT IS DECEASED

Date of Death:_____/_____/_____ **Name of Next of Kin:** _____

Relation of Next of Kin:_____ **Phone:**_____ **Email:** _____

PATIENT INFORMATION

Patient's Name:_____, _____
Last **First**

Date of Birth:__/__/__ **Medical Record #:** _____ **Race:** _____ **Ethnicity:** _____
(MM) (DD) (YYYY)

Sexual Orientation: _____ **Gender:** _____ **Gender Identity:** _____

Patient's Address: _____ **City / State:** _____

Zip Code: _____ **County:** _____ **Patient's Phone:** _____

CLINIC INFORMATION

Submitting Clinic: Name/Address: _____

Phone#_____ Fax #: _____

Requesting Clinician:_____ **NPI:**_____ **Provider ID/CHN:** _____
Full Name (Last, First) (**For SF Health Network Only**)

SPECIMEN INFORMATION

COLLECTION DATE:_____ **COLLECTION TIME:** _____

Specimen source (check one):

☐ Nasopharyngeal *(PREFERRED)* ☐ Oropharyngeal ☐ NP/OP ☐ Tracheal Aspirate ☐ Sputum ☐ Anterior Nares

☐ Pleural Fluid ☐ Nasal Mid-turbinate ☐ Nasopharyngeal Wash ☐ Bronchoalveolar Lavage (BAL) ☐ Nasal Aspirate

☐ Other: _____