



**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, HCLD (ABB)

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) _____ **CHN #** (required for providers who have a SF CHN #) _____

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: _____

For instructions on collecting and storing specimens for each test, along with electronic copies of this form, please visit our webpage at: www.sfcscp.org/phl

Comments: _____

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

TRICHOMONAS VAGINALIS TMA (Molecular Detection / NAAT)
(Endocervical, Vaginal swab and Urine sources only)
 Trichomonas vaginalis TMA

Mycoplasma genitalium TMA (Molecular Detection / NAAT)
(Urine, Vaginal, Endocervical, Urethral, Penile meatal sources only)
 Mycoplasma genitalium TMA

Herpes Simplex Virus 1/2 TMA (Molecular Detection / NAAT)
(Clinician collected Anogenital, Throat, Rash/Lesion and Oral swabs only)
 Herpes Simplex Virus 1/2 TMA

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

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
 Lymphogranuloma venereum (LGV) PCR
 Influenza PCR
 Measles PCR
 Mumps PCR
 Respiratory Panel PCR
 Gastrointestinal Panel PCR
 Norovirus PCR
 CRE PCR
 Other: _____

BACTERIOLOGY
 Gonorrhea Culture and AST (for select submitters)