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 PUBLIC HEALTH LAB USE ONLY

Test Requisition Form

(* denotes required information)

Patient Information		Submitter Information	
*Name (Last, First, Middle)		*Ordering Physician¹	
*Address		The physician or alternate contact completing this form confirms that they are compliant to the HIPPA Privacy Rule (45 CFR Parts 160 and 164) and that the fax number listed is a secure line to send test results.	
*City, State, Zip		*Diagnosis Code	
*DOB	*Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M/F <input type="checkbox"/> F/M	*Facility	
*Pregnancy Status	MRN/ID#	NPI for Facility#	
Race (Required for Detention Facilities) <input type="checkbox"/> White <input type="checkbox"/> Black/Afr Amer <input type="checkbox"/> Amer Ind/Alaskan <input type="checkbox"/> Asian Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Decline		*Address	
Ethnicity (Required for Detention Facilities) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Decline		*Phone	*Fax
Clinical Information (ie. date of onset/exposure, travel history, previous lab results)		*Alternate Contact¹ (ie. PHN/CDI/Epi)	*Phone

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"/> Aspirate (specify type):
Time	<input type="checkbox"/> Serum	<input type="checkbox"/> Vaginal	<input type="checkbox"/> Rectal	<input type="checkbox"/> Nasopharynx	<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 ___	<input type="checkbox"/> Urine	<input type="checkbox"/> Cervix	<input type="checkbox"/> Sputum Induced	<input type="checkbox"/> CSF	<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 (*Please attach worksheet/results)	<input type="checkbox"/> Cryptosporidium DFA	<input type="checkbox"/> Trichomonas NAAT
<input type="checkbox"/> N. gonorrhoeae Culture	<input type="checkbox"/> Giardia DFA	<input type="checkbox"/> HIV-1 Viral Load
<input type="checkbox"/> Enteric Pathogens ID (specify organism): (*Please attach worksheet/results)	<input type="checkbox"/> Malaria Confirmation	<input type="checkbox"/> HSV 1/2 PCR
<input type="checkbox"/> Enteric Pathogens Culture (specify organism):	<input type="checkbox"/> Blood Parasite Identification	<input type="checkbox"/> Influenza PCR Previous test results <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> Outpatient <input type="checkbox"/> Hospitalized <input type="checkbox"/> ICU <input type="checkbox"/> Outbreak <input type="checkbox"/> Inmate <input type="checkbox"/> Fatal Outbreak case#
<input type="checkbox"/> Rule Out (specify organism): (*Please attach worksheet/results)	<input type="checkbox"/> Coccidian Identification (Cyclospora sp. and Isospora sp.)	
Mycobacteriology	Serology	<input type="checkbox"/> Norovirus PCR (pre-approved only) ²
<input type="checkbox"/> AFB Smear, Culture, Susceptibility	<input type="checkbox"/> HIV- 1/2 Ag/Ab Reflex Panel	<input type="checkbox"/> Hepatitis A PCR (pre-approved only) ²
<input type="checkbox"/> MTB Complex Susceptibility Only	<input type="checkbox"/> Syphilis Reflex Panel (reverse algorithm)	<input type="checkbox"/> Measles PCR (pre-approved only) ³
<input type="checkbox"/> GeneXpert MTB/RIF PCR	<input type="checkbox"/> QuantiFERON-TB <input type="checkbox"/> *Not Incubated <input type="checkbox"/> *Incubated Time in/out: _____/_____	<input type="checkbox"/> Mumps PCR (pre-approved only) ³
<input type="checkbox"/> MTB complex Isolate (Title 17) (*Please attach worksheet/results)	<input type="checkbox"/> Hepatitis B Core Ab Total Reflex Panel	<input type="checkbox"/> Send Out (specify test):
<input type="checkbox"/> Other Test(s) consult with lab:	<input type="checkbox"/> Hepatitis C Ab Reflex Panel	
	<input type="checkbox"/> Measles IgG	

2-This test must be approved by the San Diego County Epidemiology Program, please call 619-692-8499. 3- This test must be approved by the San Diego County Immunization Program, please call 866-358-2966 option 5. Tests may be subject to incur costs to the submitter per the board approved fee schedule. Board approved fees can be found on the San Diego County Public Health Laboratory website.