

CA CERTIFIED PUBLIC HEALTH LAB #335637 CLIA #05D1066369

## COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH

## **PUBLIC HEALTH LABORATORY**

PLACE BARCODE LABEL HERE

12750 ERICKSON AVENUE DOWNEY, CA 90242 PHONE (562) 658-1330 FAX (562) 401-5999

| COMPLETE THIS FORM FOR EACH SPECIMEN AND CLICK THE " <b>PRINT</b> " BUTTON AT THE BOTTOM. |                             |   |                           |                   |                    |                       |   |                     |      |                |   |         |          |                  |  |  |
|---|-----------------------------|---|---------------------------|-------------------|--------------------|-----------------------|---|---------------------|------|----------------|---|---------|----------|------------------|--|--|
| SUBMITTER/REFERRING LABORATORY INFORMATION  |                             |   |                           |                   |                    |                       |   | REQUESTING PROVIDER |      |                |   |         |          |                  |  |  |
| FACILITY NAME:  |                             |   |                           |                   |                    |                       |   | NAME (LAST, FIRST): |      |                |   |         |          |                  |  |  |
| STREET ADDRESS:   |                             |   |                           |                   |                    |                       |   | NPI/UPIN #:         |      |                |   |         |          |                  |  |  |
| CITY, STATE, ZIP:   |                             |   |                           |                   |                    |                       |   | PROVIDER SIGNATURE: |      |                |   |         |          |                  |  |  |
| FACILITY PHONE:   |                             |   |                           |                   |                    |                       |   |                     |      |                |   |         |          |                  |  |  |
| PATIENT INFORMATION   |                             |   |                           |                   |                    |                       |   |                     |      |                |   |         |          |                  |  |  |
| NAME (LAST, FIRST, MI):   | OUTBREAK/PROJECT#           |   |                           |                   |                    |                       |   |                     |      |                |   |         |          |                  |  |  |
|   |                             |   |                           |                   |                    |                       |   | JRITY NUMBER:       |      |                |   |         |          |                  |  |  |
| STREET ADDRESS:   | J.((1.1.1                   | TOWIDEN.                                |                           |                   |                    |                       |   |                     |      |                |   |         |          |                  |  |  |
|   |                             |   |                           |                   |                    |                       |   |                     |      |                |   |         |          |                  |  |  |
| CITY, STATE, ZIP: PHONE: INSURANCE COMPANY: POLICY #:                                     |                             |   |                           |                   |                    |                       |   |                     |      |                |   |         |          |                  |  |  |
|   |                             |   |                           |                   |                    |                       |   |                     |      |                |   |         |          |                  |  |  |
| MEDICARE/MEDI-CAL/ME  |                             |   |                           |                   |                    |                       | HIP TO INSURED: SELF SPOUSE DEPENDENT                 |                     |      |                |   |         |          |                  |  |  |
| DOB (MM/DD/YEAR):   |                             | GENDER:                                 |                           |                   |                    | PREGNANCY STATUS:     |   |                     |      |                |   |         |          |                  |  |  |
|   |                             | MALE                                    | FEMA                      | ALE               | OTHER              | ₹                     | `   | YES 1               | NO   | UNKNOWN        | ١   | NOT A   | APPLICAE | BLE              |  |  |
| ETHNICITY:  | RACE:                       |   |                           |                   |                    |                       |   |                     |      |                |   |         |          |                  |  |  |
| HISPANIC<br>NON-HISPANIC/NON-LATINO<br>UNKNOWN  |                             | ANAFRICANIAN                            | NA NATIV                  | -                 |                    |                       | TEST?   |                     |      | YES            |   | NO      | UNKNOWN  |                  |  |  |
|   |                             | AMERICAN IND<br>ASIAN (SPECIF)          | KA NATIVE                 | E                 |                    | EMPLOYED IN HEALTHCAR |   |                     | ARE? | ? YES          |   | NO      | UNKNOWN  |                  |  |  |
|   |                             | ASIAN INDIAN<br>CAMBODIAN               |                           | MONG<br>PANESE    | THAI<br>VIETNAMESE | IAMESE                | SYMPTOMATIC?  |                     |      |                | YES   |         | NO       | UNKNOWN          |  |  |
|   |                             | CHINESE<br>FILIPINO                     | REAN<br>OTIAN             | OTHER AS          | R ASIAN            |                       |   |                     |      |                |   |         |          |                  |  |  |
|   |                             | BLACK/AFRICA                            |                           |                   |                    |                       | DATE OF SYMPTOM ONSET? (MM/D HOSPITALIZED?            |                     |      | SET? (MM/DD    | <u> </u>                                    |         | UNKNOWN  |                  |  |  |
|   |                             |   | ER PACIFIO                | PACIFIC ISLAND    |                    |                       |   |                     |      |                |   |         |          |                  |  |  |
|   |                             | WHITE OTHER (SPECIFY): UNKNOWN          |                           |                   |                    |                       | ICU? YES  |                     |      |                | NO  | UNKNOWN |          |                  |  |  |
|   |                             |   |                           |                   |                    |                       | RESIDENT IN A YES NO UNKNOWN CONGREGATE CARE SETTING? |                     |      |                |   |         |          |                  |  |  |
| SPECIMEN INFORMATION  |                             |   |                           |                   |                    |                       |   |                     |      |                |   |         |          |                  |  |  |
| DATE COLLECTED (MM/DD/YEAR)   |                             | TIME COLLECTED (24 HOUR FORMAT - HH:MM) |                           |                   |                    |                       | SUBMITTING LAB ACCESSION # 10                         |                     |      |                | CD-10 CODE(S)                               |         |          |                  |  |  |
| SPECIMEN SOURCE:  |                             |   |                           |                   |                    |                       | l   |                     |      |                |   |         |          |                  |  |  |
| CAPILLARY BLOOD   |                             | BAL                                     |                           | BUCCAL SWAB       |                    |                       | ERVIX   |                     |      | TISSUE (SPEC   |   | Y):     | OTH      | OTHER (SPECIFY): |  |  |
| CSF   |                             | BRONCHIAL WASH                          |                           | NASOPHARYNGEAL    |                    |                       | YE  |                     |      |                |   |         |          |                  |  |  |
| PLASMA<br>SERUM   | GASTRIC ASPIRATE NASAL WASH |   | NASAL SWAB<br>THROAT SWAB |                   |                    | LIP                   | P<br>JNG  |                     |      |                |   |         |          |                  |  |  |
| STOOL   |                             |   |                           |                   |                    |                       | NIS   |                     |      |                |   |         |          |                  |  |  |
|   |                             |   |                           |                   |                    |                       | RETHRA  | ١                   |      |                |   |         |          |                  |  |  |
| VENOUS BLOOD  |                             |   | ON SWAB VA                |                   |                    | AGINA                 |   |                     |      |                |   |         |          |                  |  |  |
|   |                             | ACTERIOLOGY/                            |                           | MYCOBACTERIOLOGY/ |                    |                       | MOLECULAR EPIDEM                                      |                     |      | OLOGY   MOLECU |   |         | STD/     |                  |  |  |
| VIROLOGY P  |                             | ARASITOLOGY                             | MYCOLOGY                  |                   |                    |                       |   |                     | HIV  |                |   | HCV     |          |                  |  |  |
|   |                             |   |                           |                   |                    |                       |   |                     |      |                |   |         |          |                  |  |  |
|   |                             |   |                           |                   |                    |                       |   |                     |      |                |   |         |          |                  |  |  |
|   |                             |   |                           |                   |                    |                       |   |                     |      |                |   |         |          |                  |  |  |
|   |                             |   |                           |                   |                    |                       |   |                     |      |                | TOXICOLOGY/CHEMISTRY/ SELECT AGENT RULE-OUT |         |          |                  |  |  |
|   |                             |   |                           |                   |                    |                       |   |                     |      |                |   | SELE(   | . I AGEN | KULE-UUI         |  |  |
|   |                             |   |                           |                   |                    |                       |   |                     |      |                |   |         |          |                  |  |  |
|   |                             |   |                           |                   |                    |                       |   |                     |      |                |   |         |          |                  |  |  |
|   |                             |   |                           |                   |                    |                       |   |                     |      |                |   |         |          |                  |  |  |
| TITLE 17/OTHER (SPECIFY)  | :                           |   |                           |                   |                    |                       |   |                     |      |                |   |         |          |                  |  |  |
|   |                             |   |                           |                   |                    |                       |   |                     |      |                |   |         |          |                  |  |  |