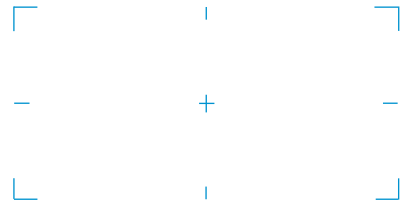




Health Care Agency
Public Health Laboratory
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Red indicates required information



CLIENT INFORMATION (REQUIRED)						
				PATIENT INFORMATION		
				HCA MEDICAL RECORD NUMBER		
				PATIENT NAME (LAST, FIRST, MIDDLE)		
				STREET ADDRESS / APT #		
OTHER CLINICIAN INFORMATION (if different from above)						
NAME / CLINIC CODE / PHONE #						
STREET ADDRESS						
CITY / STATE / ZIP						
DATE OF BIRTH		AGE	GENDER	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	
CLIENT PATIENT NUMBER						
SPECIMEN SOURCE (REQUIRED)			COLLECTION INFORMATION			
<input type="checkbox"/> Throat	<input type="checkbox"/> Stool	<input type="checkbox"/> Rectal Swab	<input type="checkbox"/> Sputum	<input type="checkbox"/> Aerosol (D1, D2, D3, F)	DATE (MM/DD/YYYY)	TIME (HH:MM)
<input type="checkbox"/> NP	<input type="checkbox"/> CSF	<input type="checkbox"/> Urine	<input type="checkbox"/> BAL	<input type="checkbox"/> Respiratory Processed		<input type="checkbox"/> AM
<input type="checkbox"/> Genital	<input type="checkbox"/> Oral Fluid	<input type="checkbox"/> Ear	<input type="checkbox"/> Gastric Aspirate	<input type="checkbox"/> Other _____ (Specify)		<input type="checkbox"/> PM
<input type="checkbox"/> Serum	<input type="checkbox"/> Plasma	<input type="checkbox"/> Whole Blood	<input type="checkbox"/> Wound	<input type="checkbox"/> Tissue	COLLECTED BY	
<input type="checkbox"/> Acute	<input type="checkbox"/> Convalescent	Onset Date _____	<input type="checkbox"/> Lesion	Specify Site: _____		
REFERENCE TEST (REQUIRED) OR						
<input type="checkbox"/> B4 Bacterial Culture for Identification, Aerobic	<input type="checkbox"/> T2 Mycobacterium Culture for Identification	<input type="checkbox"/> V4 Viral Culture for Identification				
<input type="checkbox"/> B5 Bacterial Culture for Identification, Anaerobic	<input type="checkbox"/> T6 Mycobacterium tuberculosis Culture for Identification and Susceptibility	Culture Referred As: (REQUIRED)				
<input type="checkbox"/> B13 Gonorrhea, Culture for Identification	<input type="checkbox"/> T7 Mycobacterium tuberculosis Culture for Reportable Disease Only					
<input type="checkbox"/> B20 Salmonella/Shigella, Culture for Identification						
<input type="checkbox"/> M2 Mycology/Aerobic Actinomycetes Culture for Identification						
CLINICAL TEST (REQUIRED)						
BACTERIOLOGY		MYCOBACTERIOLOGY		VIRAL LOAD		
<input type="checkbox"/> B1 Aeromonas Culture	<input type="checkbox"/> T1 Mycobacterium Culture and Sensitivity	<input type="checkbox"/> S68 HIV 1 Viral Load, TaqMan v2				
<input type="checkbox"/> B2 Bacterial Culture and Sensitivity, Aerobic	<input type="checkbox"/> T3 Mycobacterium Smear	SEROLOGY				
<input type="checkbox"/> B3 Bacterial Culture and Sensitivity, Anaerobic	<input type="checkbox"/> T4 Mycobacterium tuberculosis complex NAAT	<input type="checkbox"/> S18 Hepatitis Acute Panel				
<input type="checkbox"/> B6 Bordetella pertussis Culture and PCR	<input type="checkbox"/> T5 Mycobacterium tuberculosis, Antimicrobial Drug Levels	Hepatitis A IgM Antibody				
<input type="checkbox"/> B7 Campylobacter Culture	PARASITOLOGY		Hepatitis B Core IgM Antibody			
<input type="checkbox"/> B8 Clostridium botulinum Toxin	<input type="checkbox"/> P1 Arthropod Identification	Hepatitis B Surface Antigen Screen				
<input type="checkbox"/> B9 Diphtheria Culture	<input type="checkbox"/> P2 Cryptosporidium/Giardia Screen	Hepatitis C Antibody				
<input type="checkbox"/> B10 Escherichia coli (STEC) Culture	<input type="checkbox"/> P3 Cyclospora Screen	<input type="checkbox"/> S19 Hepatitis A IgM Antibody				
<input type="checkbox"/> B12 Gonorrhea Culture	<input type="checkbox"/> P4 Entamoeba histolytica/Entamoeba dispar Differentiation	<input type="checkbox"/> S67 Hepatitis A IgG Antibody				
<input type="checkbox"/> B14 Gonorrhea, Microscopic Exam	<input type="checkbox"/> P5 Helminth Identification	<input type="checkbox"/> S20 Hepatitis B Core IgM Antibody				
<input type="checkbox"/> B15 Haemophilus ducreyi Culture	<input type="checkbox"/> P6 Isospora Screen	<input type="checkbox"/> S21 Hepatitis B Core Total Antibody				
<input type="checkbox"/> B16 Legionella Culture	<input type="checkbox"/> P7 Malaria/Blood Parasites Screen	<input type="checkbox"/> S22 Hepatitis B Surface Antigen Screen				
<input type="checkbox"/> B17 Occult Blood	<input type="checkbox"/> P8 Microsporidium Screen	<input type="checkbox"/> S23 Hepatitis B Surface Antigen Antibody				
<input type="checkbox"/> B19 Salmonella/Shigella Culture	<input type="checkbox"/> P9 Ova and Parasite Exam	<input type="checkbox"/> S24 Hepatitis C Antibody				
<input type="checkbox"/> B21 Streptococcus Group A Culture	<input type="checkbox"/> P10 Paragonimus Screen	<input type="checkbox"/> S31 HIV 1, 2 Antigen/Antibody Screen				
<input type="checkbox"/> B22 Syphilis Darkfield, Microscopic Exam	<input type="checkbox"/> P11 Pinworm Exam	<input type="checkbox"/> S28 HIV 1 Oral Fluid Screen				
<input type="checkbox"/> B25 Urinalysis	<input type="checkbox"/> P12 Pneumocystis Screen	<input type="checkbox"/> S43 Measles Antibody				
<input type="checkbox"/> B27 Vibrio Culture	VIROLOGY		<input type="checkbox"/> S58 Syphilis Screen			
<input type="checkbox"/> B29 Yersinia Culture	<input type="checkbox"/> V1 Chlamydia/Gonorrhea NAAT	<input type="checkbox"/> S59 Syphilis TP-PA Confirmation				
MYCOLOGY		<input type="checkbox"/> V2 Rabies DFA	<input type="checkbox"/> S61 Toxoplasma Antibody			
<input type="checkbox"/> M1 Mycology Primary Culture	<input type="checkbox"/> V3 Viral Culture	<input type="checkbox"/> V5 Viral Culture, Herpes Simplex Virus	SEROLOGY OTHER			
	<input type="checkbox"/> V8 Influenza PCR		<input type="checkbox"/> S32 Immunology Other Antibody			
			Specify _____			

Other Tests / Notes: