Stanislaus County
Public Health Laboratory
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Stephen A. Willis, Laboratory Director

Stanislaus County HEALTH SERVICES AGENCY

LABEL

PATIENT INFORMATION (REQUIRED)

PATIENT NAME (Last, First) ____________ SEX ❑ M ❑ F ___/___/___ DATE OF BIRTH (MM/DD/YR) ____________ MEDICAL RECORD #

STREET ADDRESS ____________ CITY/STATE/ZIP

CLIENT INFORMATION (REQUIRED)

SUBMITTOR NAME AND ADDRESS

HSA

❑ CMO ❑ HMO
❑ MMO ❑ PMO
❑ TMO ❑ FPC
❑ PEDS ❑ SPC
❑ CD ❑ TB
❑ STD/HIV
❑ REFUGEE

ORDERING PROVIDER

SUPERVISING PHYSICIAN
(Medi-Cal Requirement)

NPI#

ICD9 CODE(S)

SPECIMEN INFORMATION (REQUIRED)

TYPE OF SPECIMEN/SOURCE

❑ BLOOD ❑ SPUTUM
❑ SERUM ❑ BRONCH WASH
❑ PLASMA ❑ THROAT
❑ URINE ❑ CSF
❑ URETHRA ❑ PLEURAL FLUID
❑ CERVIX/VAG ❑ PERICARDIAL FLUID
❑ PENIS ❑ SYNOVIAL FLUID
❑ FECES/RECTAL ❑ THORACENTESIS

❑ BIOPSY TISSUE (Specify) ____________

❑ EXUDATE (Specify) ____________

❑ OTHER (Specify) ____________

SPECIMEN COLLECTION INFORMATION

____
COLLECTED BY

___/___/___ ____________
DATE (MM/DD/YR) TIME

BILLING INFORMATION – Please print clearly (attach copy of insurance card)

RESPONSIBLE PARTY

RELATIONSHIP: ❑ SELF ❑ SPOUSE ❑ CHILD
❑ OTHER:____________

ADDRESS

TELEPHONE
(   )   -

BILL TO: ❑ SUBMITTOR ❑ PATIENT ❑ MEDICARE ❑ MEDI-CAL ❑ MEDI-CAL HN ❑ MEDI-CAL BLUE CROSS ❑ FPACT ❑ CHDP
❑ MIA ❑ HCUBS ❑ CLIENT ACCOUNT____________ ❑ OTHER (specify)____________

CHECK TEST (REQUIRED)

BACTERIOLOGY

❑ Bacterial Culture for Identification
suspected ____________
❑ Bacterial Culture, Aerobic
❑ Bacterial Culture, Anaerobic
❑ Campylobacter Culture
❑ Diphtheria Culture
❑ Escherichia coli 0157 Culture
❑ Gonorrhoeae Culture
❑ Gram Stain
❑ Haemophilus influenza for Serotyping
❑ Neisseria meninigitidis for Serotyping
❑ Salmonella/ Shigella Culture
❑ Streptococcus pneumoniae for Serotyping
❑ Syphilis Darkfield, Microscopic Exam
❑ Other (specify)

PARASITOLOGY

❑ Arthropod Identification
❑ Giemsa Stain (thin & thick films)
❑ Helminth Identification
❑ Malaria/Blood Parasite Slide Confirmation
❑ Modified AFB Smear for Cryptosporidium, Cyclospora, and Isospora
❑ Ova and Parasite Exam
❑ Wet Mount

MYCOBACTERIOLOGY

❑ Acid Fast Bacilli Culture and Smear (Smear not performed on blood or bone marrow specimens)

VIROLOGY

❑ Rabies DFA
❑ R-Mix Culture for Respiratory Viruses (Influenza A and B, Parainfluenza 1, 2, 3, Adenovirus, and RSV)
❑ DFA for Respiratory Viruses (Specimen must be nasal-pharyngeal aspirate or washing)

MYCOLOGY

❑ Fungus Culture for Identification
❑ Fungus Culture
❑ Coccidioides immitis for Confirmation (Referred to State)

TOXICOLOGY

❑ Blood Lead

SEROLOGY/MOLECULAR

❑ Chlamydia by Nucleic Acid Amplification
❑ Gonorrhea by Nucleic Acid Amplification
❑ HIV Serum Antibody Screen
❑ Syphilis Screen (RPR)
❑ Syphilis TP-PA Confirmation
❑ West Nile Virus Antibody (Include Case History Form)

CONTACT LABORATORY FOR REQUEST FORM FOR REFERENCE SPECIMENS AND OTHER TESTS.
COMMENTS:

PATIENT AUTHORIZATION

____________ ____________
Patient Signature Date