"VIRAL LOAD" REPORTING FORM

PRIMARY/INDEX LAB'S NAME: _____ **ADDRESS:** _____

City State Zip

PHONE: ( ) _____ - _____ CLIA ID# _____ **DATE SENT (mm/dd/yyyy):** ____/____/_____ **BY**_____

LAST NAME		FIRST NAME		MIDDLE NAME	PROVIDER'S NAME
DATE OF BIRTH (mm/dd/yyyy)	**GENDER(1-4)**	**ACCESSION NUMBER**	**DATE TESTED (mm/dd/yyyy)**	**DATE DRAWN (mm/dd/yyyy)**	Address
____/___/_____			____/___/_____	____/___/_____	City State Zip Phone **CA** ( )
MEDICAL RECORD NUMBER		**SOCIAL SECURITY NMBER**		**MD**	Name Phone ( )
RESULTS	_____ **[ ]copies/mL [ ] log(10)copies/mL**			**TYPE OF TEST ("X")**	**[ ] ASBA(Organon) [ ] RT-PCR (Roche) [ ] bDNA(Bayer) [ ] Other**

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Mail to: County of Los Angeles Department of Public Health
600 S. Commonwealth Ave, Suite #1260
Los Angeles, CA 90005-4001
Help Desk: 213-351-8516

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