County of Los Angeles Public Health
Public Health Laboratory

CA CERTIFIED PUBLIC HEALTH LAB #335637
CLIA #05D1066369

COUNTY OF LOS ANGELES
DEPARTMENT OF PUBLIC HEALTH

PUBLIC HEALTH LABORATORY

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

PLACE BARCODE LABEL HERE

COMPLETE THIS FORM FOR EACH SPECIMEN AND CLICK THE "**PRINT**" BUTTON AT THE BOTTOM.

SUBMITTER/REFERRING LABORATORY INFORMATION (ALL FIELDS REQUIRED)	REQUESTING PROVIDER
FACILITY NAME (**REQUIRED**):	NAME (LAST, FIRST) (**REQUIRED**):
STREET ADDRESS (**REQUIRED**):	NPI/UPIN #:
CITY, STATE, ZIP (**REQUIRED**):	PROVIDER SIGNATURE:
FACILITY PHONE (**REQUIRED**):	

PATIENT INFORMATION (REQUIRED FIELDS ARE INDICATED BELOW):

NAME (LAST, FIRST, MI) (**REQUIRED**):	OUTBREAK/PROJECT #
MEDICAL RECORD NUMBER (**REQUIRED**):	SOCIAL SECURITY NUMBER:
STREET ADDRESS (**REQUIRED**)	
CITY, STATE, ZIP (**REQUIRED**):	PHONE (**REQUIRED**):
INSURANCE COMPANY:	POLICY #:
MEDICARE/MEDI-CAL/MEDICAID #:	RELATIONSHIP TO INSURED: ○ SELF ○ SPOUSE ○ DEPENDENT

DOB (MM/DD/YEAR)(REQUIRED):	GENDER (REQUIRED):	PREGNANCY STATUS (REQUIRED):
	○ MALE ○ FEMALE ○ OTHER	○ YES ○ NO ○ UNKNOWN ○ NOT APPLICABLE

ETHNICITY: (SELECT ONLY ONE) (REQUIRED)

- ○ HISPANIC
- ○ NON-HISPANIC/NON-LATINO
- ○ OTHER

RACE: (SELECT ONLY ONE) (REQUIRED)

- ○ AMERICAN INDIAN/ALASKA NATIVE
- ASIAN (SPECIFY):
  - ○ ASIAN INDIAN
  - ○ CAMBODIAN
  - ○ CHINESE
  - ○ FILIPINO
  - ○ HMONG
  - ○ JAPANESE
  - ○ KOREAN
  - ○ LAOTIAN
  - ○ THAI
  - ○ VIETNAMESE
  - ○ OTHER ASIAN
- ○ BLACK/AFRICAN AMERICAN
- ○ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER
- ○ WHITE
- ○ OTHER

REQUIRED FOR CORONAVIRUS TESTING ONLY:

	YES	NO	UNKNOWN
FIRST TEST?	○	○	○
SYMPTOMATIC?	○	○	○
DATE OF SYMPTOM ONSET? (MM/DD/YEAR)			
HOSPITALIZED?	○	○	○
ICU?	○	○	○
EMPLOYED IN HEALTHCARE?	○	○	○
RESIDENT IN A CONGREGATE CARE SETTING?	○	○	○

SPECIMEN INFORMATION (ALL FIELDS REQUIRED EXCEPT ICD-10):

DATE COLLECTED (MM/DD/YEAR)	TIME COLLECTED (24 HOUR FORMAT - HH:MM)	SUBMITTING LAB ACCESSION #	ICD-10 CODE(S)

SPECIMEN SOURCE (SELECT ONLY ONE) (REQUIRED):

○ CAPILLARY BLOOD	○ BAL	○ BUCCAL SWAB	○ CERVIX	○ TISSUE (SPECIFY):	○ OTHER (SPECIFY):
○ CSF	○ BRONCHIAL WASH	○ NASOPHARYNGEAL	○ EYE		
○ PLASMA	○ GASTRIC ASPIRATE	○ NASAL SWAB	○ LIP		
○ SERUM	○ NASAL WASH	○ THROAT SWAB	○ LUNG		
○ STOOL	○ SPUTUM (INDUCED)	○ RECTAL SWAB	○ PENIS		
○ URINE	○ SPUTUM	○ WOUND SWAB	○ URETHRA		
○ VENOUS BLOOD		○ LESION SWAB	○ VAGINA		

IMMUNOSEROLOGY/ VIROLOGY	BACTERIOLOGY/ PARASITOLOGY	MYCOBACTERIOLOGY/ MYCOLOGY	MOLECULAR EPIDEMIOLOGY	MOLECULAR STD/ HIV/HCV
Varicella IgG Antibody	- N/A	- N/A	- N/A	- N/A
- N/A	- N/A	- N/A	- N/A	- N/A
- N/A	- N/A	- N/A	- N/A	- N/A
- N/A	- N/A	- N/A	- N/A	- N/A
- N/A	- N/A	- N/A	- N/A	**TOXICOLOGY/CHEMISTRY/ SELECT AGENT RULE-OUT**
- N/A	- N/A	- N/A	- N/A	
- N/A	- N/A	- N/A	- N/A	- N/A
- N/A	- N/A	- N/A	- N/A	- N/A
- N/A	- N/A	- N/A	- N/A	- N/A
- N/A	- N/A	- N/A	- N/A	- N/A

TITLE 17/OTHER (SPECIFY): VZV PCR (please select specimen source above)

PRINT