



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) | RACE: (SELECT ONLY ONE) (REQUIRED) | | REQUIRED FOR CORONAVIRUS TESTING ONLY: | | |
| HISPANIC NON-HISPANIC/NON-LATINO OTHER | AMERICAN INDIAN/ALASKA NATIVE | | FIRST TEST? YES NO UNKNOWN | | |
| | ASIAN (SPECIFY): | | SYMPTOMATIC? YES NO UNKNOWN | | |
| | ASIAN INDIAN | HMONG | THAI | DATE OF SYMPTOM ONSET? (MM/DD/YEAR) | |
| | CAMBODIAN | JAPANESE | VIETNAMESE | HOSPITALIZED? YES NO UNKNOWN | |
| | CHINESE | KOREAN | OTHER ASIAN | ICU? YES NO UNKNOWN | |
| | FILIPINO | LAOTIAN | | EMPLOYED IN HEALTHCARE? YES NO UNKNOWN | |
| | BLACK/AFRICAN AMERICAN | | | RESIDENT IN A CONGREGATE CARE SETTING? YES NO UNKNOWN | |
| | NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER | | | | |
| WHITE | | | | | |
| OTHER | | | | | |
| 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 CSF PLASMA SERUM STOOL URINE VENOUS BLOOD | BAL BRONCHIAL WASH GASTRIC ASPIRATE NASAL WASH SPUTUM (INDUCED) SPUTUM | BUCCAL SWAB | CERVIX | TISSUE (SPECIFY): | OTHER (SPECIFY): |
| | | NASOPHARYNGEAL | EYE | | |
| | | NASAL SWAB | LIP | | |
| | | THROAT SWAB | LUNG | | |
| | | RECTAL SWAB | PENIS | | |
| | | WOUND SWAB LESION SWAB | URETHRA VAGINA | | |
| IMMUNOSEROLOGY/ VIROLOGY | | BACTERIOLOGY/ PARASITOLOGY | MYCOBACTERIOLOGY/ MYCOLOGY | MOLECULAR EPIDEMIOLOGY | MOLECULAR STD/ HIV/HCV |
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| TITLE 17/OTHER (SPECIFY): | | | | | |