

SUBMITTER INFORMATION												
REQUIRED FIELDS	Submitting Facility:											
	Address:											
	Requesting Provider:						National Provider Identifier (NPI):					
	Phone:						Secure Fax:					
	PATIENT DEMOGRAPHICS-PLEASE PRINT CLEARLY											
	Last Name:				First Name:				MRN/SSN:			
	Address:							Date of Birth:				
	Cell Phone:						Home/work Phone:					
	Pregnancy Status:			Yes	No	Unknown	Gender:		Female	Male	Other	
				Sex:		Female	Male	Other				
Race:		American Indian or Alaska Native			Asian		Black or African American			White		
		Native Hawaiian or Other Pacific Islander				Other			Unknown			
Ethnicity:		Hispanic/Latino				Non-Hispanic/Latino			Unknown			
SPECIMEN TYPE/SOURCE-PLEASE CHECK APPROPRIATE BOX(ES)												
Axilla/Groin Swab			Nasopharyngeal			Serum			Urine			
Cerebral Spinal Fluid			Oropharyngeal/Throat			Expectorated Sputum			Whole Blood			
Lesion: _____			Plasma			Induced Sputum			Stool			
Nasal Swab			Rectal Swab			Other:						
Date Collected:				Time Collected:				Diagnosis Code:				
AVAILABLE ASSAYS-PLEASE SELECT ALL REQUESTED TESTS												
TEST REQUEST INFORMATION	Bacteriology		B. pertussis culture			Campylobacter culture			Carbapenamase PCR			
			Enteric Screen			E. coli O157 culture			Shiga Toxin			
			Salmonella culture			Shigella culture			Vibrio culture			
			Other:									
	BT/Select Agent Rule-out:		B. anthracis			Brucella			Burkholderia			
			F. tularensis			Y. pestis			Other:			
	Mycobacteriology		AFB Definitive ID			AFB Smear/Culture			AFB Blood Culture			
			PCR for M. tuberculosis Complex			Other:						
	Mycology		Candida auris screen			Fungus Culture			Definitive Fungal ID			
	Parasitology		Ova & Parasite screen			Malaria Smear			Parasite Identification			
			Other:									
	Serology		Hepatitis A IgG Ab			Hepatitis A IgM Ab			<b>Hepatitis B Surface Ag</b>			
			Hepatitis B Surface Ab			Hepatitis B Core Antibody			Hepatitis B Core IgM Ab			
			<b>Hepatitis C Ab</b>			<b>HIV 1/2 Ag/Ab Combo Assay</b>			Qualitative Syphilis (RPR)			
			Quantitative Syphilis (VDRL/RPR)			Syphilis Confirmation			Other:			
	Virology/Molecular		Gastrointestinal Panel			Hepatitis B Viral Load			Hepatitis C Viral Load			
			Herpes Simplex Virus 1 & 2 DNA			HIV-1 Viral Load			Influenza virus PCR			
			Influenza virus subtyping			Measles PCR*			Mumps PCR*			
			Nonvariola/Orthopox PCR			Norovirus PCR			Respiratory Panel			
			SARS CoV-2/COVID 19 NAAT			RSV PCR			Other:			
Surveillance		CEIP (list organism):						SARS CoV-2 Sequencing				
		Title 17 Submission (list organism):						Other:				
For all requested tests, please attach/include relevant patient history (date of onset, symptoms, exposure and travel history, treatment(s), submitting laboratory accession #, pertinent laboratory results/findings, etc.), Case # and/or PUI #. For Officer Exposure requests (serology tests in bold), testing will only be performed if specimen is accompanied by a lab requisition, EMS-6 form AND patient consent/judicial order.												
Comments:												

\*Contact CCH Communicable Disease Control (925-313-6740) prior to submission of specimens. Please submit related supplemental forms.