



**CITY AND COUNTY OF SAN FRANCISCO
PUBLIC HEALTH LABORATORY**
101 Grove Street, Room 419
San Francisco, CA 94102
Tel: (415) 554-2800 Fax: (415) 431-0651
CLIA ID # 05D0643643
Director: Godfred Masinde, PhD

THIS SPACE IS FOR LABORATORY USE ONLY

COVID-19 and INFLUENZA A+B TESTING REQUISITION FORM

Instructions:

- **ALL FIELDS ON THE FORM ARE FEDERALLY MANDATED. EVERY FIELD MUST BE COMPLETED OR SPECIMEN WILL BE REJECTED.**
- Please type or print legibly.
- This form is intended for COVID-19 test requisitions only.
- Please include a printed copy of this form with the specimen submission.
- For electronic copies of this form, please visit our webpage at: <https://www.sfcdcp.org/public-health-lab/forms-specimen-culture-submission/>.

Additional Information:

- For guidance on specimen collection and storage, please refer to SFDPH's Clinical and Testing Guidance: <https://www.sfcdcp.org/infectious-diseases-a-to-z/coronavirus-2019-novel-coronavirus/coronavirus-2019-information-for-healthcare-providers/>
- Hospitals and large health systems are asked to provide transport of specimens to PHL between the hours of 8 AM and 8 PM Monday-Friday and 9 AM to 5 PM Saturday-Sunday. If you do not have the capacity to transport specimen, SFDPH can arrange for scheduled transport. Please contact the Communicable Disease Control Unit (CDCU) between the hours of 8 AM and 5 PM at (415) 554-2830 and follow the automated instructions to schedule transport.
- Testing guidelines are subject to change. Please refer to the latest advisories here: <https://www.sfcdcp.org/health-alerts-emergencies/health-alerts/>.

PLEASE COMPLETE REQUISITION FORM ON REVERSE SIDE. PLEASE ATTACH A COPY WITH THE SPECIMEN.



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TEST REQUESTED (PLEASE USE ONE FORM PER SPECIMEN): COVID-19 Qualitative RT-PCR Testing ONLY
 COVID-19 AND Influenza A+B Testing COVID-19 AND Influenza A+B AND Respiratory Syncytial Virus (RSV) Testing

Is the patient experiencing any of the following symptoms? Yes No Unknown Date of symptom onset? ___/___/___

- Fever or chills
- Headache
- Congestion or runny nose
- Cough
- Diarrhea
- Loss of Smell and Taste
- Sore Throat
- Muscle or body aches
- Nausea or vomiting
- Shortness of Breath
- Fatigue

Is patient a resident of a congregate care setting? Yes No Unknown

Is the patient employed in healthcare? Yes No Unknown

Is the patient pregnant? Yes No Unknown

Has the patient been hospitalized? Yes No Unknown

Is the patient in the ICU? Yes No Unknown

IF PATIENT IS DECEASED

Date of Death: ___/___/___ Name of Next of Kin: _____

Relation of Next of Kin: _____ Phone: _____ Email: _____

PATIENT INFORMATION

Patient's Name: _____, _____
Last First

Date of Birth: ___/___/___ Medical Record #: _____ Race: _____ Ethnicity: _____
(MM) (DD) (YYYY)

Sexual Orientation: _____ Gender: _____ Gender Identity: _____

Patient's Address: _____ City / State: _____

Zip Code: _____ County: _____ Patient's Phone: _____

CLINIC INFORMATION

Submitting Clinic: Name/Address: _____

Phone# _____ Fax #: _____

Requesting Clinician: _____ NPI: _____ Provider ID/CHN: _____
Full Name (Last, First) (For SF Health Network Only)

SPECIMEN INFORMATION

COLLECTION DATE: _____ COLLECTION TIME: _____

Specimen source (check one):

- Nasopharyngeal (PREFERRED) Oropharyngeal NP/OP Tracheal Aspirate Sputum Anterior Nares
- Pleural Fluid Nasal Mid-turbinate Nasopharyngeal Wash Bronchoalveolar Lavage (BAL) Nasal Aspirate
- Other: _____