



**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

THIS SPACE IS FOR LABORATORY USE ONLY

**BACTERIOLOGY / PARASITOLOGY SUBMISSION FORM**  
(FOR MYCOBACTERIOLOGY, USE THE GENERAL REQUEST FORM)

**ALL FIELDS ARE REQUIRED – PLEASE TYPE OR PRINT LEGIBLY**

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| <b><u>Patient information:</u></b>   |  |
| <b>Patient's Name:</b> _____ , _____<br><div style="text-align: center; margin-left: 100px;">Last, <span style="margin-left: 150px;">First</span> <span style="margin-left: 100px;">(Middle)</span></div>  |  |
| <b>Gender:</b> _____ <b>Date of Birth:</b> _____ / _____ / _____ <b>Medical Record #:</b> _____  |  |
| <b>Patient's Address:</b> _____ <b>Phone:</b> _____  |  |
| <b>City / State:</b> _____ <b>Zip Code:</b> _____  |  |
| <b><u>Submitting Clinic Information:</u></b><br><br>Submitting Laboratory/Clinic: _____<br><br>Requesting Clinician: _____<br>(REQUIRED)   | <b>Submitter's identification of organism:</b><br><br><hr/> <b>TEST REQUESTED:</b><br><br><b>BACTERIOLOGY</b><br><input type="checkbox"/> Enteric Culture for Identification / Title 17 Submission<br><input type="checkbox"/> Special Bacteriology Culture for Identification**<br><input type="checkbox"/> Carbapenemase Gene PCR (includes KPC, NDM, IMP, VIM, and OXA48 genes)<br><input type="checkbox"/> Clearance for: _____<br><input type="checkbox"/> Gastrointestinal Panel PCR<br><input type="checkbox"/> Other: _____<br><br><b>PARASITOLOGY</b><br><input type="checkbox"/> Malaria PCR** (submit whole blood AND thin smears)<br><input type="checkbox"/> Clearance for: _____<br>**Additional information required below. |
| <b>COLLECTION DATE:</b> _____<br><br><b>Specimen source (check one):</b><br><input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> CSF<br><input type="checkbox"/> Wound, location: _____<br><input type="checkbox"/> Tissue, type: _____<br><input type="checkbox"/> Other, specify: _____<br><input type="checkbox"/> Blood smear (for malaria): <input type="checkbox"/> Thin <input type="checkbox"/> Thick |  |

**SUBMITTER'S LABORATORY FINDINGS**

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|--|---|
| <b>FOR ALL CULTURES FOR IDENTIFICATION:</b><br><br>Cultures made from original clinical sample were: <input type="checkbox"/> Pure <input type="checkbox"/> Mixed<br>If mixed, list other organisms present: _____<br>Indicate colony count where applicable (e.g. urine): _____<br>Number of times organism isolated from the patient: _____<br>Medium(s) on which primary growth was obtained: _____<br>Were stained smears or other preparations made directly from clinical material?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, was this organism seen? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Medium on which organism is being submitted: _____<br>Date inoculated: _____<br>Conditions prior to mailing:    Temp: _____    Atmosphere: _____    Length: _____ | <b>FOR SPECIAL BACTERIOLOGY ONLY:</b><br><i>Required:</i> Brief but complete case history, therapy, outcome (attach additional forms if necessary):<br><br><hr/> <b>FOR MALARIA ONLY (Required):</b><br>Physician's Name: _____<br>Physician's Phone #: _____<br>Date on onset: _____<br>Travel history, symptoms, treatment: _____ |
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Submitter's laboratory findings (biochemical results, Gram stain results, agglutination results; please be comprehensive—attach additional forms as necessary):