



**CITY AND COUNTY OF SAN FRANCISCO
PUBLIC HEALTH LABORATORY**

101 Grove Street, Room 419
San Francisco, CA 94102
Tel: (628) 206-7100 Fax: (415) 431-0651
CLIA ID # 05D0643643
Director: Godfred Masinde, PhD, HCLD (ABB)

THIS SPACE IS FOR LABORATORY USE ONLY

ALL FIELDS IN BOLD ARE REQUIRED – SPECIMENS WITH INCOMPLETE FORMS WILL BE REJECTED

PLEASE TYPE OR PRINT LEGIBLY, OR AFFIX PREPRINTED LABEL HERE

Patient's Name: _____, _____
Last, First (Middle)

Medical Record # (if present): _____ **Address:** _____ **Zip Code:** _____

Gender: _____ **Date of Birth:** ____ / ____ / ____ **City / State:** _____ **Phone:** _____

Submitting Clinic: _____
(REQUIRED)

Requesting Clinician: _____
(REQUIRED) **Full Name** (Last, First)
PRINT LEGIBLY, OR SPECIMEN WILL BE REJECTED

--	--	--	--	--	--

CHN # (required for providers
who have a SF CHN #)

For instructions on
collecting and storing
specimens for each
test, along with
electronic copies of
this form, please visit
our webpage at:
www.sfgdcp.org/phl.

Comments:

INSURANCE

PLEASE CHECK ONE: ☐ Medi-Cal ☐ Family PACT ☐ S.F. Health Plan ☐ Blue Shield
☐ Blue Cross ☐ Uninsured ☐ Other: _____ ☐ Not provided by patient

If patient provided insurance information:

Patient Insurance I.D. #: _____ **Diagnosis Code(s):** _____

COLLECTION DATE: _____ ☐ Clinician-Collected Throat ☐ Urine
Specimen source (check one): ☐ Clinician-Collected Rectal ☐ Self-Collected Throat ☐ Rash/Lesion
☐ Blood ☐ Plasma ☐ Self-Collected Rectal ☐ Clinician-Collected Vaginal ☐ Sputum
☐ Oral Fluid ☐ Serum ☐ Urethral ☐ Genital ☐ Self-Collected Vaginal ☐ Other: _____

TEST REQUESTED (PLEASE USE ONE FORM PER SPECIMEN)

HIV SCREENING

Rapid Test (RT) result:

☐ (-) ☐ (+) ☐ (+,+) ☐ (+,-)
☐ RT not performed

Collection time: _____

☐ Pooled RNA (RT Negative)
☐ HIV Ab/Ag Screen (CMIA)
☐ Individual RNA
☐ RT Positive Confirmation

HIV VIRAL LOAD (RT-PCR) *

☐ Time collected: _____

HEPATITIS SCREENING

Collection time: _____

☐ Hepatitis C (HCV) Antibody
Screen*
☐ Hepatitis C Rapid Test Positive
Confirmation*

HCV Rapid Test (RT) result:

☐ (-) ☐ (+)

☐ Hepatitis B Screening Panel

**CHLAMYDIA / GONORRHEA TMA
(Molecular Detection / NAAT)**

☐ Chlamydia TMA
☐ Gonorrhea TMA

**TRICHOMONAS VAGINALIS TMA
(Molecular Detection / NAAT)**

(Endocervical, Vaginal swab and Urine sources only)
☐ *Trichomonas vaginalis* TMA

**Mycoplasma genitalium TMA
(Molecular Detection / NAAT)**

(Urine, Vaginal, Endocervical, Urethral, Penile meatal
sources only)
☐ *Mycoplasma genitalium* TMA

**Herpes Simplex Virus 1/2 TMA
(Molecular Detection / NAAT)**

(Clinician collected Anogenital, Throat, Rash/Lesion and
Oral swabs only)
☐ *Herpes Simplex Virus 1/2* TMA

SEROLOGY

☐ Syphilis – Screen (RPR)
☐ Syphilis – TPPA
☐ Herpes Simplex 2 EIA

BACTERIOLOGY

☐ Gonorrhea Culture and AST (for select
submitters)

MYCOBACTERIA SEROLOGY

☐ QuantiFERON (TB blood test) *

Collection time required: _____

Incubation start date: _____

Incubation start time: _____

Incubation stop time: _____

MYCOBACTERIOLOGY

☐ Acid Fast Smear
☐ Specimen for Isolation
☐ Culture for Identification

Submitter's ID: _____

☐ TB Drug Susceptibility

☐ TB Molecular Detection (PCR)

MOLECULAR DIAGNOSTICS

☐ Lymphogranuloma venereum (LGV) PCR
☐ Influenza PCR
☐ Measles PCR
☐ Mumps PCR
☐ Mpox PCR
☐ Respiratory Panel PCR
☐ Gastrointestinal Panel PCR
☐ Norovirus PCR
☐ CRE PCR
☐ Other: _____