



SACRAMENTO COUNTY PUBLIC HEALTH LABORATORY
 4600 BROADWAY, Suite 2300, SACRAMENTO, CA. 95820
 PHONE (916) 874-9231 FAX (916) 874-9432

CULTURE / BLOOD FILM / SPECIMEN SUBMISSION FORM

MYCOBACTERIOLOGY – MYCOLOGY – GENERAL BACTERIOLOGY – MALARIA – VIROLOGY

Patient Information:

Last Name _____ First Name _____ DOB ____ / ____ / ____ Sex ____
 Street Address _____ City _____ County _____ Zip Code ____
 Date of Onset ____ / ____ / ____ Medical Record # _____ Occupation _____
 Significant Clinical or Travel History _____

Submitting Laboratory Information:

Laboratory Name _____
 Address _____

 Phone _____ Fax _____

Attending Physician Information: (Mandatory)

Name _____
 Address _____

 County _____ Phone _____

Specimen Information:

Submitter's Specimen Identification # _____ Specimen Source _____ Date collected ____ / ____ / ____

Reason for Submission

- Required by Title 17 – Isolate from a specimen submitted by a Sacramento County health care provider (Includes all primary *Mycobacterium tuberculosis* isolates, multi-drug resistant *M. tuberculosis* isolates, *Salmonella sp.* isolates and blood film slides with malarial parasites) No Fee
- Select Agent Identification or Rule-Out (Anthrax, Brucella, Tularemia, Coccidioides, Plague, etc.) No Fee
- Culture for Identification (General Bacteriology or Fungus reference culture) No Fee
- New or Emerging Pathogen Screening (Please Circle) No Fee
 Respiratory Virus Isolation Vesicular Rash Screen Other _____
- Primary Test Request (Please Circle) Fee Charged (Additional tests available on laboratory requisition form.)
 TB Drug Susceptibility TB Direct Probe of Sputum Specimen TB Quantiferon Test (Contact Lab)

Submitter's Identification _____

(Attach a copy of your worksheet)

Significant Findings _____ (Use reverse of form for additional space.)

Note:

Preliminary and Final Results of Reportable Conditions covered by Title 17 are Faxed to the Health Officer of the health jurisdiction where the health care provider who first submitted the specimen is located and to the patient's county Health Officer.

For Public Health Laboratory Use Only

Date Received ____ / ____ / ____ PH Lab Presumptive ID _____

Date Presumptive ID Faxed ____ / ____ / ____ Preliminary Report Faxed ____ / ____ / ____ Date Final Faxed ____ / ____ / ____

By _____ By _____ By _____