



SAN JOAQUIN COUNTY PUBLIC HEALTH
 LABORATORY 1601 E. HAZELTON AVE.
 STOCKTON, CA 95205
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 CLIA # 05D0643989

LABORATORY USE ONLY	
LAB. NUMBER _____	DATE/TIME RECEIVED _____

<p>SUBMITTER</p> <p>Agency/County Name: _____</p> <p>Site Name: _____</p> <p>Street Address: _____</p> <p>City, State, Zip: _____</p> <p>Physician/NPI#: _____</p> <p>(REQUIRED information)</p> <p>Phone: _____</p> <p>Fax: _____</p>	<p>Patient Name: _____</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">Last Name</td> <td style="width: 33%; text-align: center;">First Name</td> <td style="width: 33%; text-align: center;">Middle Initial</td> </tr> </table> <p>Street Address: _____</p> <p>City _____ State _____ Zip _____</p> <p>Phone: _____</p> <p>County of Residence _____</p> <p>Medical Record # _____ Accession # _____</p> <p>Birth date: _____ GENDER : M <input type="checkbox"/> F <input type="checkbox"/> Trans M <input type="checkbox"/> Trans F <input type="checkbox"/></p> <p>Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> non-Hispanic</p> <p>Race: <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Other, Specify: _____</p> <p>Pregnancy Status: <input type="checkbox"/> Pregnant <input type="checkbox"/> Not Pregnant <input type="checkbox"/> Unknown <input type="checkbox"/> N/A</p> <p>Diagnosis Code/ICD 10 Code: _____</p> <p>IF PATIENT IS DECEASED, Specify Date of Death: _____</p>	Last Name	First Name	Middle Initial
Last Name	First Name	Middle Initial		

DATE SPECIMEN TAKEN: _____ **TIME SPECIMEN TAKEN:** _____

Calredie Number (If available): _____

Specimen Source:

Dry Swab (Lesions) using sterile Nylon, Polyester or Dacron swabs Body site _____

Note: Swabs may be submitted dry or in viral Transport medium (VTM)

Testing	Case History (REQUIRED information) Missing information from below might lead to the specimen rejection	Triage Information (REQUIRED information) Missing information from below might lead to the specimen rejection
<input type="checkbox"/> Poxvirus PCR	<p>Date onset symptoms (Rash): _____</p> <p>Vaccination History <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, Date of Smallpox vaccine (Vaccinia): _____</p> <p>Travel History <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Travel Information: _____</p> <p>PHS Consulted? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Symptomatic: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Disease Suspected: _____</p> <p>Clinical Findings and Symptoms:</p> <p>Exposure History: _____</p> <p>Contact with other individual <input type="checkbox"/> Yes <input type="checkbox"/> No</p>