



SAN JOAQUIN COUNTY
PUBLIC HEALTH LABORATORY
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STOCKTON, CA 95205
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LABORATORY USE ONLY

LAB. NUMBER _____

DATE/TIME RECEIVED _____

COVID/Influenza Requisition version 6 11.16.2023

SUBMITTING AGENCY INFORMATION

Site Name: _____

Street Address: _____

City, State, Zip: _____

Physician/NPI#: _____

(REQUIRED information)

Phone: _____

Fax: _____

Patient Name: _____

Last Name First Name Middle Initial

Street Address: _____

City _____ State _____ Zip _____

Phone: _____

County of Residence _____

Medical Record # _____ Accession # _____

Birth date: _____ Gender: M F Trans M Trans F

Ethnicity: Hispanic non-Hispanic

Race: Asian Black White American Indian/Alaskan Native
 Pacific Islander Unknown Other, Specify: _____

Pregnancy Status: Pregnant Not Pregnant Unknown N/A

Diagnosis Code/ICD 10 Code: _____

IF PATIENT IS DECEASED, Specify Date of Death: _____

BILLING INFORMATION: (Please Submit a copy of the Insurance card and verification)

Submitter Medi-Cal Medicare FPACT Health Plan of San Joaquin Health Net Other: _____

No Charge (Title 17 or Surveillance)

Policy #: _____

DATE SPECIMEN TAKEN: _____ TIME SPECIMEN TAKEN: _____

- Nasal Pharyngeal (NP) Sputum Bronchial Alveolar Lavage Mid-Turbinate Other: _____
 Throat Oropharyngeal (OP) NP + OP Nares

Testing	Case History	Patient Symptoms
<input type="checkbox"/> COVID-19 NAAT <input type="checkbox"/> Multiplex Flu + COVID-19 NAAT (Symptomatic patients only) <input type="checkbox"/> COVID-19 Whole Genome Sequencing (WGS) <input type="checkbox"/> Influenza Diagnostic PCR (Influenza A & B) <input type="checkbox"/> Surveillance Influenza Subtyping <input type="checkbox"/> Flu A <input type="checkbox"/> Flu B <input type="checkbox"/> BioFire Respiratory Panel* (22 Targets: 18 Virus, 4 Bacteria)	Date Symptoms Onset: _____ Is Patient Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No Is Patient In ICU? <input type="checkbox"/> Yes <input type="checkbox"/> No Fatal Case? <input type="checkbox"/> Yes <input type="checkbox"/> No PHS Consulted? <input type="checkbox"/> Yes <input type="checkbox"/> No SARS-CoV-2 Testing Status (Required for all Non-COVID-19 Testing) <input type="checkbox"/> Detected <input type="checkbox"/> Not Detected <input type="checkbox"/> Unknown	<input type="checkbox"/> Fever ≥ 37.8° <input type="checkbox"/> Cough <input type="checkbox"/> Sore Throat <input type="checkbox"/> Myalgia <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Other: _____

*BioFire Respiratory Panel will require Billing Information