

Riverside University Health System - Public Health

Public Health Laboratory Test Request Form

Address: 4065 County Circle Drive Riverside, CA 92503

Phone: (951) 358-5070 Fax: (951) 358-5015

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CLIA ID# 05D0571882

CA Certified Public Health Laboratory #1158

PH Laboratory Use Only

Website: <http://www.rivcolab.org/>

If required information (highlighted in red bold below) is included on submitter specimen label place below **INSTEAD OF** filling out patient information.

Last Name	Submitting Facility	Date Received:
First Name		
Date of Birth	MRN/2nd Identifier #	Program
Gender: Male [] Female []		Program Contact Person
Street Address	Date of Collection	
	Collection Time	Disease Control Information
City/State/Zip	Date of Onset	Specimen for Clearance? []
	Physician & NPI#	CalREDIE Number
	Pregnant [] Yes [] No	ICD-10 Code(s):
Race: [] American Indian or Alaska Native, [] Asian Indian, [] Other Asian, [] Black or African American, [] Chinese, [] Filipino, [] Guamanian or Chamorro, [] Japanese, [] Korean, [] Native Hawaiian, [] Other Pacific Islander, [] Samoan, [] Vietnamese, [] White, [] Other Race		Ethnicity: [] Hispanic or Latino, [] Not Hispanic or Latino

Additional Comments/Information:

Specimen Source (Required)

<input type="checkbox"/> Biopsy	<input type="checkbox"/> Endocervical	<input type="checkbox"/> Penis/Urethra	<input type="checkbox"/> Serum	<input type="checkbox"/> Vaginal
<input type="checkbox"/> Blood	<input type="checkbox"/> Lesion/Pustule	<input type="checkbox"/> Peritoneal Fluid	<input type="checkbox"/> Sputum	<input type="checkbox"/> Vag/Rectal
<input type="checkbox"/> Bronchoalveolar Lavage	<input type="checkbox"/> Nasal	<input type="checkbox"/> Plasma	<input type="checkbox"/> Stool (feces)	<input type="checkbox"/> Wound (specify site)
<input type="checkbox"/> Capillary (blood)	<input type="checkbox"/> Nasopharyngeal	<input type="checkbox"/> Pleural Fluid	<input type="checkbox"/> Throat	<input type="checkbox"/> Other-specify below
<input type="checkbox"/> CSF	<input type="checkbox"/> Oral Fluid	<input type="checkbox"/> Rectal	<input type="checkbox"/> Urine	

Specimen Type Isolate Other - specify _____ Submitted on _____

Test to be Performed - Submit One Form for Each Specimen Type

<input type="checkbox"/> CT/GC NAT Panel (includes all tests below)	<input type="checkbox"/> Hepatitis Panel (includes all tests below)	Enteric Culture
<input type="checkbox"/> GC NAT 87591	<input type="checkbox"/> Hepatitis A Total Antibody 86708	<input type="checkbox"/> Culture Campylobacter 87046
<input type="checkbox"/> CT NAT 87491	<input type="checkbox"/> Hepatitis B Surface Antibody 86706	<input type="checkbox"/> Culture Salmonella/Shigella 87045
Nucleic Acid Amplification Test (NAT)	<input type="checkbox"/> Hepatitis B Core Total Antibody 86704	<input type="checkbox"/> Culture STEC 87046
<input type="checkbox"/> Norovirus NAT 87797	HIV	<input type="checkbox"/> Isolate for Identification - Enteric 87077
<input type="checkbox"/> Influenza A/B NAT 87797	<input type="checkbox"/> HIV Ag/Ab Combo EIA Screen 87389	<input type="checkbox"/> Shiga Toxin Screen 87427
<input type="checkbox"/> Respiratory Panel NAT 87633	<input type="checkbox"/> HIV 1/2 Conf/Diff 86701 86702	<input type="checkbox"/> Other:
<input type="checkbox"/> Influenza-SARS-CoV-2 Multiplex NAT 87636		
<input type="checkbox"/> Mpox NAT 87593	Syphilis	Aerobic Culture
<input type="checkbox"/> Measles NAT (#Please answer below) 87797	<input type="checkbox"/> Syphilis EIA Screen 86592	<input type="checkbox"/> Culture Aerobic Bacteria 87070
<input type="checkbox"/> Mumps NAT (#Please answer below) 87797	<input type="checkbox"/> Syphilis Confirmation^ 86592 86593 86780	<input type="checkbox"/> Isolate for Identification - Aerobic 87077
#Measles/Mumps Vaccination? Yes [] No [] Estimated Date: Dose 1 _____ Dose 2? Yes [] No [] Estimated Date: Dose 2 _____	<input type="checkbox"/> RPR Titer (Monitoring Previous Positive Only) 86593	<input type="checkbox"/> Culture GC 87081
	Positive Screen: YES [] NO []	<input type="checkbox"/> Culture Strep Group A/B screen 87081
	List Screen Test: _____	
Parasites	^Syphilis Confirmation will ONLY be performed for positive FDA-approved screen test	Mycobacteria
<input type="checkbox"/> O & P Concentrate/Trichrome 87209 87177		<input type="checkbox"/> Culture AFB 87015 87206 87116
<input type="checkbox"/> Fecal Leukocyte (WBC) 87205	Special Serology	<input type="checkbox"/> MTB/RIF NAT 87556
<input type="checkbox"/> O & P and WBC Panel 87209 87177 87205	West Nile Virus IgM Antibody 86788	<input type="checkbox"/> Isolate for Identification- AFB 87149
<input type="checkbox"/> Pinworm 87172		<input type="checkbox"/> MTB Susceptibility 87190
<input type="checkbox"/> ID of Parasite 87169		<input type="checkbox"/> Title 17 MTB Isolate Retention~
<input type="checkbox"/> Other	Mycology / Fungus	~Test(s) Requested or Title 17 MTB Isolate Retention Requested (Please include AST Report with Title 17):
DFA Test	<input type="checkbox"/> Culture Fungus 87102	<input type="checkbox"/> Quantiferon (*QFT) IGRA × 86480
<input type="checkbox"/> DFA Pneumocystis 87281	<input type="checkbox"/> ID Fungus / Yeast 87107 87106	× Date/ Time Incubated: _____
<input type="checkbox"/> DFA Cryptosporidium/Giardia 87274 87269		Date/ Time Removed from Incubator: _____

Sendout to external reference laboratory (CDC, CDPH, or other PH Laboratory)

Sendout Test Request Information:

Incubation Temp.: _____

***QFT specimens must be incubated 16-24 hrs at 37°C**

TESTING ALGORITHMS

HIV 1/2 SEROLOGY **TAT:** EIA: Negative = 2 days / Positive = 4 days reflex to C/D NAT Sendout = 7 days

Specimens testing initially reactive by HIV-1 & 2 Antibody/Antigen Combo Enzyme Immunoassay (EIA) will be retested in duplicate. Repeatedly reactive specimens will be confirmed by HIV Antibody Confirmation/Differentiation (C/D) test. Specimens with discordant results will be sent to a reference lab for HIV NAT.

SYPHILIS SEROLOGY **TAT:** EIA: Negative = 3 days / Positive = 4 days reflex to RPR / 7 days reflex to TPPA
RPR = 3 days TPPA = 3 days

Specimens giving reactive or equivocal results will be retested in duplicate. If the repeat is again equivocal a fresh serum specimen will be requested. Reactive and equivocal results will be automatically confirmed by RPR / TPPA (if necessary).

Specimens previously testing POSITIVE by a FDA-approved screening test will be confirmed by RPR / TPPA (if necessary). Screen test MUST be listed on the Lab Test Request or full algorithm with be performed.

Specimens for monitoring PREVIOUSLY POSITIVE patients will be tested by RPR titer ONLY.

MYCOBACTERIA / TB **TAT:** Acid-Fast (FI) Smear = 24 hours Culture: Negative = 6 weeks / Positive = 21 days
MTB/RIF NAT = 24 hours AST = 28 days Quantiferon = 2 days

Respiratory specimens from new patients found smear positive for Acid Fast Bacilli will be tested by the GeneXpert nucleic acid amplification test (NAT) for *Mycobacterium tuberculosis* complex /Rifampin (MTB/RIF).

Mycobacterium tuberculosis culture isolates from new patients shall be tested for drug susceptibility by the broth method.

Specimens from sterile sites will ONLY be tested if collected appropriately. DO NOT send swabs unless pre-approved by the lab.

PARASITOLOGY **TAT:** O & P = 4 days ID of Parasite (Blood Smear/Skin Scraping/Insect or Worm) = 24 hours
Pinworm = 24 hours DFA = 3 days Fecal Leukocyte (WBC) = 3 days

Stool specimens will be examined for routine Ova and Parasites (O & P) only. Cyclospora/Isospora testing will be performed only if requested by physician.

Please provide Giemsa or Wright stained thick and thin smears for blood parasite identification.

BACTERIOLOGY **TAT:** Gram Stain = 24 hours Shiga-toxin EIA = 24 hours
Culture: Negative = 3 - 7 days (varies by culture)
Identification / further typing = up to 3 weeks (varies by culture)

Isolates requiring further typing such as for Salmonella, Shigella, and E. coli will be sent to the California Department of Public Health (CDPH), Microbial Diseases Laboratory (MDL).

RESPIRATORY PANEL **TAT:** Respiratory Panel NAT = 2 days

Nasopharyngeal specimens transported in VTM/UTM will be tested for the following analytes: Adenovirus, Coronavirus 229E, Coronavirus HKU1, Coronavirus NL63, Coronavirus OC43, **SARS-CoV-2**, Human Metapneumovirus, Human Rhinovirus/Enterovirus, **Influenza A** (including subtypes H1, H3 and H1-2009), **Influenza B**, Parainfluenza Virus 1, Parainfluenza Virus 2, Parainfluenza Virus 3, Parainfluenza Virus 4, Respiratory Syncytial Virus, Bordetella parapertussis, **Bordetella pertussis**, Chlamydia pneumoniae, and Mycoplasma pneumoniae.

INFLUENZA **TAT:** A/B NAT = 3 days

Respiratory specimens sent for diagnostic testing must be sent with this Lab Test Request form or ordered electronically.

Respiratory specimens sent for surveillance testing must be sent with the Influenza Submission Form available on the lab website.

Respiratory specimens testing positive for Influenza A will be further subtyped. Untypeable specimens may be sent to the CDPH, Viral and Rickettsial Disease Laboratory (VRDL) for further testing.

FUNGUS/MYCOLOGY **TAT:** Culture: Negative = 4 weeks / Positive = 3-6 weeks. Fungus Isolate for ID = 2-4 weeks

All Fungal specimens will be sent out for testing to the San Bernardino County Public Health Laboratory.