


**CLINICAL/ MOLECULAR TESTING**

 <p><b>COUNTY OF HUMBOLDT</b>          DEPARTMENT OF HEALTH &amp; HUMAN SERVICES  <b>PUBLIC HEALTH LABORATORY</b>          PEPPER STOCKTON, LABORATORY DIRECTOR          CLIA 05D0666113, MEDICARE/ MEDI-CAL ID #          LAB58595F 529 I ST., EUREKA CA 95501          PHONE: (707) 268-2179 FAX: (707) 445-7640          EMAIL: HCPHL@CO.HUMBOLDT.CA.US</p>	<b>PATIENT #</b>
	<b>P.H. LAB USE ONLY</b>
	<b>DATE &amp; TIME RECEIVED</b>
<b>LAB SPECIMEN #</b>	

**INFORMATION MUST BE PROVIDED TO PROCESS TESTING-PLEASE PRINT CLEARLY**

PATIENT'S LAST NAME	FIRST	MI	<b>LAB CLIENT #</b>
<b>ETHNICITY:</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic      Unknown			<b>SUBMITTING AGENCY</b>
<b>RACE:</b> American Indian or Alaska Native      Asian      Multiple Race Native Hawaiian or Other Pacific Islander      Other      White      Black/African American			
<b>GENDER:</b> Female      Male      Trans-Female      Trans-Male      Unknown			
<b>DOB</b>	<b>CHART#</b>	<b>SOCIAL SECURITY#</b>	
PREGNANCY STATUS (if known)			
RESPONSIBLE PARTY		PATIENT PHONE #	
PATIENT ADDRESS			<b>NAME OF PHYSICIAN</b>
CITY/STATE/ZIP			

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the County of Humboldt Public Health Laboratory. I am financially responsible for any non-covered services. I also authorize the Public Health Laboratory to release any information required to process this claim.

**SIGNED** ..... **DATE** .....

If this is a confidential test and any balance not covered by insurance cannot be billed to your home,

**ICD10 CODE:**

BILL OUR ACCOUNT       INSURANCE (MUST INCLUDE COPY OF CARD)

PROOF OF ELIGIBILITY REQUIRED OR ACCOUNT WILL BE BILLED. ATTACH PHOTOCOPY OR COMPUTER PRINT-OUT TO BACK OF FORM.

<b>SPECIMEN SOURCE:</b>	OROPHARYNGEAL SWAB	SERUM	CSF
	BUCCAL SWAB	VAGINAL SWAB	RECTAL SWAB
	LESION SWAB	NASOPHARYNGEAL	URINE
			STOOL
			OTHER _____

<b>DATE &amp; TIME COLLECTED</b>	<b>COLLECTED BY</b>
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**SPECIMEN CONDITION:**     FROZEN     REFRIGERATED     ROOM TEMP     OTHER \_\_\_\_\_

TEST REQUESTED:	CPT:	TEST REQUESTED:	CPT:	TEST REQUESTED:	CPT:		
<b>Respiratory PCR</b>		<b>Sexually-Transmitted Infection</b>		<b>BACTERIOLOGY</b>			
RSV, INFLUENZA A/B, & COVID-19	87798	CT/ GC PCR	87491 / 87591	STOOL CULTURE	87045		
Covid-19 & Influenza A/ B		CHLAMYDIA (CT) ONLY PCR	87491	Rule out: _____			
INFLUENZA A/ B subtyping		GONORRHEA (GC) ONLY PCR	87591	TITLE 17	TITLE 17		
PERTUSSIS		TRICHOMONAS VAGINALIS (TV) PCR	87661	Rule out: _____			
ENTEROVIRUS		GONORRHEA AST	87181	<b>SYPHILIS</b>			
Biofire Respiratory Panel (22 targets)	87633	<b>Gastrointestinal PCR</b>		<input type="checkbox"/> SYPHILIS SCREEN (RPR; TPPA)	86592 / 86780		
<b>Vaccine preventable disease PCR</b>		Biofire Gastrointestinal Panel (22 targets)	87507	<input type="checkbox"/> SYPHILIS TITER (RPR)	86593		
MEASLES	87798	NOROVIRUS	87798	<b>Comments:</b>			
MUMPS		STEC (Shiga Toxin)					
<b>OTHER</b>		<b>Poxvirus PCR</b>					
SEND OUT: _____		VZV	87798				