CA CERTIFIED PUBLIC HEALTH LAB #335637
CLIA #05D1066369

COUNTY OF LOS ANGELES
DEPARTMENT OF PUBLIC HEALTH

PUBLIC HEALTH LABORATORY
12750 ERICKSON AVENUE
DOWNEY, CA 90242
PHONE (562) 658-1300
FAX (562) 401-5999

PLACE BARCODE LABEL HERE

NOROVIRUS TEST REQUEST FORM

PH PROGRAM:	REQUESTING PHYSICIAN/PHONE/EMAIL:	REQUEST DATE (MM/DD/YEAR):
HOSPITAL/FACILITY NAME AND ADDRESS:	HOSPITAL/FACILITY STAFF CONTACT NAME/PHONE:	

NUMBER PERSONS AT RISK:

TOTAL NUMBER OF CLINICAL CASES:

NUMBER OF CASES HOSPITALIZED:

NUMBER OF CASES WHO DIED:

TOTAL NUMBER OF CASES TESTED/LAB CONFIRMED:

OUTBREAK/INVESTIGATION #

____

IS THIS AN URGENT REQUEST?
☐ YES
☐ NO

SPECIMENS PREVIOUSLY TESTED FOR:
☐ OVA/PARASITES
☐ BACTERIAL DIARRHEAL PATHOGENS

INSTITUTION SETTING:
☐ LONG TERM CARE ☐ RESTAURANT/CATERING
☐ HOSPITAL ☐ CRUISE SHIP
☐ SCHOOL/CAMP ☐ JAIL
☐ OTHER (SPECIFY)
____

DATE OF FIRST CASE (MM/DD/YEAR):

DATE OF LAST CASE (MM/DD/YEAR):

SUSPECTED SOURCE:
☐ FOOD-BORNE ☐ IMPORTED/TRAVEL ☐ PERSON-TO-PERSON
☐ WATER-BORNE ☐ UNKNOWN

IF SOURCE IDENTIFIED, NOTE ANY ADDITIONAL INFORMATION AVAILABLE:

SYMPTOMATIC* (YES/NO)	ACCN #	PATIENT NAME (LAST,FIRST)	ID/MRN #	DOB	SEX	ONSET DATE	COLLECT DATE

FOR LAB USE ONLY

REVIEWED/APPROVED BY: DATE: DIRECTOR APPROVAL:	SPECIMEN RECEIVED BY: DATE/TIME:
MOL. EPI UNIT RECEIPT DATE:	NORO PCR REPORT DATE: CALICINET SEQUENCE REPORT DATE:

(Rev 1/14)

*** LAB DIRECTOR CONSULTATION AND APPROVAL REQUIRED IF PATIENT ASYMPTOMATIC**