San Joaquin County Public Health Services
health grows here

SAN JOAQUIN COUNTY
PUBLIC HEALTH LABORATORY
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LABORATORY USE ONLY

LAB. NUMBER _____ DATE/TIME RECEIVED _____

COVID/Influenza Requisition version 10 1.21.2025

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) ☐ Nasal + OP ☐ Nares ☐ Conjunctival Swab

Testing

- ☐ **COVID-19 NAAT**
- ☐ **Multiplex Flu + COVID-19 NAAT (Symptomatic patients only)**
- ☐ **COVID-19 Whole Genome Sequencing (WGS)**
- ☐ **Influenza Diagnostic PCR (Influenza A & B)**
- ☐ **Novel/Avian Influenza (H5N1) Rule-Out**
- ☐ **Surveillance Influenza Subtyping** ☐ **Flu A** ☐ **Flu B**
- ☐ **BioFire Respiratory Panel* (22 Targets: 18 Virus, 4 Bacteria)**

Case History

Date Symptoms Onset: _____

****Is Patient Hospitalized?**	☐ **Yes**	☐ **No**
****Is Patient In ICU?**	☐ **Yes**	☐ **No**
(Testing prioritized for either)		
Fatal Case?	☐ **Yes**	☐ **No**
PHS Consulted?	☐ **Yes**	☐ **No**
Patient in Long Term Care?	☐ **Yes**	☐ **No**
Patient receive Flu vaccination?	☐ **Yes**	☐ **No**
Patient has H5N1 Exposure? (See back of form for criteria)	☐ **Yes**	☐ **No**

SARS-CoV-2 Testing Status
(Required for all Non-COVID-19 Testing)

☐ **Detected** ☐ **Not Detected** ☐ **Unknown**

Patient Symptoms

- ☐ **Fever ≥ 37.8°**
- ☐ **Cough**
- ☐ **Sore Throat**
- ☐ **Myalgia**
- ☐ **Nausea/Vomiting**
- ☐ **Diarrhea**
- ☐ **Shortness of Breath**
- ☐ **Conjunctivitis**
- ☐ **Other:** _____

*BioFire Respiratory Panel will require Billing Information

** Hospitalized and ICU fields are required to help our laboratory prioritize testing for enhanced surveillance

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A DIVISION OF
HEALTH CARE
SERVICES AGENCY

Human Avian Influenza A(H5N1) Exposure Criteria

Please indicate H5N1 exposure by check marking the relevant box:

Exposure Criteria (within the 10 days prior to symptom onset):

Exposure to animals infected with H5N1 influenza virus (defined as follows):

☐ Close contact (within six feet) with infected animals; such exposures can include, but are not limited to: handling, slaughtering, defeathering, butchering, culling, caring for, or milking; OR

☐ Preparing or consuming raw animal products, or consuming uncooked or undercooked food or related uncooked food products, including unpasteurized milk, from infected animals; OR

☐ Direct contact with surfaces contaminated with feces, unpasteurized milk or other unpasteurized dairy products, or animal parts (e.g., carcasses, internal organs) from infected animals; OR

Exposure to a person infected with H5N1 influenza virus (defined as follows):

☐ Exposure to an infected person: Close (within six feet), unprotected (without use of respiratory and eye protection) contact with a person who is a symptomatic confirmed, probable, or suspected H5N1 influenza case (e.g., in a household or healthcare facility); OR

Occupational exposure:

☐ Laboratory exposure: Unprotected exposure to H5N1 influenza virus in a laboratory.