

**OFFICE OF LABORATORY SERVICES**

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PLACE BARCODE HERE
 OLS USE ONLY

FOOD LABORATORY SPECIMEN SUBMISSION FORM

PATIENT INFORMATION

(if applicable)

PATIENT #1

LAST NAME	FIRST NAME	MI
DATE OF BIRTH		SS# (last 4 only, optional)
COUNTY OF RESIDENCE	SEX <input type="checkbox"/> Female <input type="checkbox"/> Male	
STREET ADDRESS		
CITY	STATE	ZIP

PATIENT #2

LAST NAME	FIRST NAME	MI
DATE OF BIRTH		SS# (last 4 only, optional)
COUNTY OF RESIDENCE	SEX <input type="checkbox"/> Female <input type="checkbox"/> Male	
STREET ADDRESS		
CITY	STATE	ZIP

NOTE: PLEASE USE BACK OF THIS FORM FOR PATIENT INFORMATION IF MORE THAN 2 PERSONS ARE INVOLVED.

SUBMITTER INFORMATION

FACILITY NAME		
MAILING ADDRESS		
CITY	STATE	ZIP
COUNTY		
ATTENTION TO:		
PHONE NO.		
FAX NO.		

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Reason/ID:

ACC:

DE:

CKD:

DATE OF COLLECTION:**TEST REQUESTED:**

- | | |
|--|-----------------------------------|
| <input type="checkbox"/> Routine Food Testing* | <input type="checkbox"/> Other ID |
| <input type="checkbox"/> Food Filth | Specify: |

*Includes testing for: *Salmonella* spp., *Shigella* spp., *S. aureus*, *Escherichia coli* O157:H7, *C. jejuni*, and coliforms.

ROUTINE FOOD SAMPLE INFORMATION:

Name of Investigator	
Phone # of Investigator	
Specimen Description	
Manufacturer	
Lot Number	
Date & Time Served	
Date & Time of First Symptoms	
Number of persons consuming food	
Number of ill persons	
Suspected Organism(s)	

FOOD FILTH SAMPLE INFORMATION

Name of Investigator	
Phone # of Investigator	
Specimen Description	
Manufacturer	
Where Purchased or Collected	
Reason for Examination	