OFFICE OF LABORATORY SERVICES
Andrea M. Labik, Sc.D. / Director
167 11th Avenue
South Charleston, WV 25303
PH: (304) 558-3530
FX: (304) 558-2006 or 6210

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 ☐ Female ☐ 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 ☐ Female ☐ 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.		

OLS USE ONLY	ACC:
☐ UNSAT	DE:
Reason/ID:	CKD:

DATE OF COLLECTION:	
TEST REQUESTED:	
☐ Routine Food Testing*	☐ Other ID
☐ 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	

FAILURE TO COMPLETE THIS FORM IN ITS ENTIRETY MAY RESULT IN DELAYED TEST RESULTS

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FOOD LABORATORY SPECIMEN SUBMISSION FORM ADDENDUM

PATIENT #3

LAST NAME	FIRST NAME	MI
DATE OF BIRTH	SS# *(LAST 4 ONLY, OPTIONAL)*	
COUNTY OF RESIDENCE	SEX ☐ Female ☐ Male	
STREET ADDRESS		
CITY	STATE	ZIP

PATIENT #4

LAST NAME	FIRST NAME	MI
DATE OF BIRTH	SS# *(LAST 4 ONLY, OPTIONAL)*	
COUNTY OF RESIDENCE	SEX ☐ Female ☐ Male	
STREET ADDRESS		
CITY	STATE	ZIP

PATIENT #5

LAST NAME	FIRST NAME	MI
DATE OF BIRTH	SS# *(LAST 4 ONLY, OPTIONAL)*	
COUNTY OF RESIDENCE	SEX ☐ Female ☐ Male	
STREET ADDRESS		
CITY	STATE	ZIP

PATIENT #6

LAST NAME	FIRST NAME	MI
DATE OF BIRTH	SS# *(LAST 4 ONLY, OPTIONAL)*	
COUNTY OF RESIDENCE	SEX ☐ Female ☐ Male	
STREET ADDRESS		
CITY	STATE	ZIP

PATIENT #7

LAST NAME	FIRST NAME	MI
DATE OF BIRTH	SS# *(LAST 4 ONLY, OPTIONAL)*	
COUNTY OF RESIDENCE	SEX ☐ Female ☐ Male	
STREET ADDRESS		
CITY	STATE	ZIP

PATIENT #8

LAST NAME	FIRST NAME	MI
DATE OF BIRTH	SS# *(LAST 4 ONLY, OPTIONAL)*	
COUNTY OF RESIDENCE	SEX ☐ Female ☐ Male	
STREET ADDRESS		
CITY	STATE	ZIP

PATIENT #9

LAST NAME	FIRST NAME	MI
DATE OF BIRTH	SS# *(LAST 4 ONLY, OPTIONAL)*	
COUNTY OF RESIDENCE	SEX ☐ Female ☐ Male	
STREET ADDRESS		
CITY	STATE	ZIP

PATIENT #10

LAST NAME	FIRST NAME	MI
DATE OF BIRTH	SS# *(LAST 4 ONLY, OPTIONAL)*	
COUNTY OF RESIDENCE	SEX ☐ Female ☐ Male	
STREET ADDRESS		
CITY	STATE	ZIP