

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 INFORMAT (if applicable)	ION				DATE OF COLLECTION	ON:			
(ii applicable)			PAT	TIENT #1	TEST REQUESTED:				
LAST NAME	FIRST	FIRST NAME			☐ Routine Food Testing*		☐ Other ID		
					☐ Food Filth		Specify:		
DATE OF BIRTH SS# (LAS			AST 4 ONLY, OPTIONAL)		*Includes testing for: <i>Salmonella</i> spp., <i>Shigella</i> spp,. <i>S. aureus</i> , <i>Escherichia coli</i> O157:H7, <i>C. jejuni</i> , and coliforms.				
COUNTY OF RESIDENCE		SEX							
		☐ Fe	male \square Male	,	ROUTINE FOOD SAM	MDI E INEODI	MATION		
STREET ADDRESS					Name of	VIF LL IIVI OIVI	WATION.		
011.2217.331.200					Investigator				
CITY STA		·E	ZIP		Phone # of				
CITT	SIAIE		211		Investigator				
			PAT	TIENT #2	mvooligator				
LAST NAME	FIRST	JAME	I MI	TILIVI #2	Specimen				
2.0110.002	THOT WILL		''''		Description				
DATE OF BIRTH		99# /		OTIONAL)					
DATE OF BIRTH	33# (L)		AST 4 ONLY, OPTIONAL)		Manufacturer				
COUNTY OF DECIDENCE		CEV			Lot Number				
COUNTY OF RESIDENCE		SEX			Date & Time				
		☐ Female ☐ Male			Served				
STREET ADDRESS					Date & Time of				
					First Symptoms				
CITY	STATE		ZIP		Number of				
					persons				
					consuming food				
NOTE: PLEASE USE INFORMATION IF MOR					Number of ill				
IN CHARACTON II MOL	<u> </u>		DINO AIRE IIIVO	LVLD.	persons				
SUBMITTER INFORM	MATION				Suspected				
FACILITY NAME					Organism(s)				
MAILING ADDRESS					FOOD FILTH SAMPL	E INFORMAT	ION:		
					Name of				
CITY	STATE		ZIP		Investigator				
	0.7.1.2	0.7.1.2			Phone # of				
COUNTY					Investigator				
COUNTY									
ATTENTION TO:					Specimen				
ATTENTION TO:					Description				
DUONE NO									
PHONE NO.					Manufacturer				
					Where Purchased				
FAX NO.					or Collected				
OLS USE ONLY			ACC:		Reason for				
UNSAT			DE:		Examination				
Reason/ID:			CKD.						

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FOOD LABORATORY SPECIMEN SUBMISSION FORM ADDENDUM

				PATIENT #3					PATIENT #7	
LAST NAME	FIRST NAME			MI	LAST NAME	FIRS	ST NAME		MI	
DATE OF BIRTH		SS# (LAST 4 ONLY, OPTIONAL)			DATE OF BIRTH	SS# (SS# (LAST 4 ONLY, OPTIONAL)			
COUNTY OF RESIDENCE		SEX			COUNTY OF RESIDENCE	CF.	SEX			
		☐ Female ☐ Male			OCCUPATION NEORDEMOL			☐ Female ☐ Male		
STREET ADDRESS		☐ I elliale ☐ Iviale			STREET ADDRESS			□ i ellidie □ ividie		
STREET ADDRESS					STREET ADDRESS					
CITY	STAT	E	ZIP		CITY	S	ΓATE	ZIP		
			1	PATIENT #4					PATIENT #8	
LAST NAME	FIRST N				LAST NAME	FIRST NAME			MI	
LAST IVAIVIL TINST		VAIVIE		IVII	LASTINAIVIL	Tine	TITOTIVAME		IVII	
DATE OF BIRTH		SS# (LAST 4 ONLY, OPTIONAL)			DATE OF BIRTH	SS# (SS# (LAST 4 ONLY, OPTIONAL)			
COLINITY OF DECIDENCE		CEV			COUNTY OF DECIDEN	<u> </u>	SEX			
COUNTY OF RESIDENCE		SEX			COUNTY OF RESIDENCE					
		☐ Female ☐ Ma		☐ Male				male	☐ Male	
STREET ADDRESS					STREET ADDRESS					
CITY	STAT	E	ZIP		CITY	S	ГАТЕ	ZIP		
	l .			PATIENT #5					PATIENT #9	
LAST NAME	ME FIRST NAM				LAST NAME	FIRST N			MI	
DATE OF BIRTH		SS# (LAST 4 ONLY, OPTIONAL)			DATE OF BIRTH		SS# (SS# (LAST 4 ONLY, OPTIONAL)		
COUNTY OF RESIDENCE		SEX			COUNTY OF RESIDENCE	Œ	SEX			
COUNTY OF RESIDENCE		SEX	male		COUNTY OF RESIDENCE	CE	SEX	male		
		SEX	male	☐ Male		CE	SEX	emale	☐ Male	
COUNTY OF RESIDENCE STREET ADDRESS			male	☐ Male	COUNTY OF RESIDENCE STREET ADDRESS	CE		emale	☐ Male	
	STAT	☐ Fe	male ZIP	□ Male				zIP	☐ Male	
STREET ADDRESS	STAT	☐ Fe			STREET ADDRESS		☐ Fe			
STREET ADDRESS	STATI	□ Fe		PATIENT #6	STREET ADDRESS	S	☐ Fe		PATIENT #10	
STREET ADDRESS CITY		Fe AME	ZIP	PATIENT #6	STREET ADDRESS CITY	S	TATE ST NAME	ZIP	PATIENT #10	
STREET ADDRESS CITY LAST NAME		Fe AME	ZIP	PATIENT #6	STREET ADDRESS CITY LAST NAME	S'	TATE ST NAME	ZIP	<i>PATIENT #10</i>	
STREET ADDRESS CITY LAST NAME DATE OF BIRTH		E SS# (ZIP	PATIENT #6 MI ONLY, OPTIONAL)	STREET ADDRESS CITY LAST NAME DATE OF BIRTH	S'	TATE ST NAME SS# (ZIP	<i>PATIENT #10</i>	
STREET ADDRESS CITY LAST NAME DATE OF BIRTH		□ Fe	ZIP	PATIENT #6	STREET ADDRESS CITY LAST NAME DATE OF BIRTH	S'	TATE ST NAME SS# (ZIP	PATIENT #10 MI ONLY, OPTIONAL)	
STREET ADDRESS CITY LAST NAME DATE OF BIRTH COUNTY OF RESIDENCE		□ Fe	ZIP	PATIENT #6 MI ONLY, OPTIONAL)	STREET ADDRESS CITY LAST NAME DATE OF BIRTH COUNTY OF RESIDENCE	S'	TATE ST NAME SS# (ZIP	PATIENT #10 MI ONLY, OPTIONAL)	