GUAM PUBLIC HEALTH LABORATORY
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
123 Chalan Kareta, Mangilao, GUAM 96913
Telephone: (671) 735-7158/7141

GPHL LABORATORY NUMBER

DATE RECEIVED

(PLEASE PRINT LEGIBLY)

ORDERING/PRIMARY PHYSICIAN:

ADDRESS:
Street:
City: State:
Country: Zip Code:
Phone No.:

SUBMITTING LABORATORY:

ADDRESS:
Street:
City: State:
Country: Zip Code:
Phone No.:

I. PATIENT IDENTIFICATION

LAST NAME	FIRST NAME AND MIDDLE INITIAL

RESIDENT ADDRESS (Physical place of residence Street, City, Zip Code)

Street:

City: Zip Code:

PHONE NO.:

OCCUPATION	RACE	DATE OF BIRTH	SEX

CLINICAL DIAGNOSIS

DATE OF ONSET

LABORATORY EXAMINATION REQUESTED

CATEGORY OF AGENT SUSPECTED

SPECIFIC AGENT SUSPECTED

II. SPECIMEN INFORMATION

1. SOURCE OF SPECIMEN
☐ HUMAN
☐ OTHER (Specify):

2. ORIGINAL MATERIAL
*TYPE OF SPECIMEN:
DATE OF COLLECTION:
TRANSPORT MEDIUM:
*SPECIFY SITE OF COLLECTION

3. SEROLOGY OF SPECIMEN
COLLECTION DATE:
☐ ACUTE (S1):
☐ CONVALESCENT (S2):
☐ S3:
☐ S4:
☐ OTHER (Specify):

4. SEROLOGY OF SPECIMEN
☐ PURE ISOLATE
☐ MIXED CULTURE
☐ OTHER (Specify):
DATE OF ORIGINAL CULTURE:
PRIMARY ISOLATON MEDIA:
COLLECTON SITE OF ORIGINAL SPECIMEN:
DATE OF CULTURE SUBMITTED AND TRANSPORT MEDIUM USED:
SUSPECTED IDENTIFICATION:
OTHER ORGANISMS FOUND:
OTHER INFORMATION:

III. CLINIC HISTORY

1. CLINICAL SIGNS AND SYMPTOMS
☐ FEVER
☐ EXANTHEMA (Specify Type):
☐ RESPIRATORY SIGNS:
☐ CENTRAL NERVOUS SYSTEM INVOLVEMENT:
☐ GASTROINTESTINAL INVOLVEMENT:

2. ADDITIONAL INFORMATION
TRAVEL HISTORY:
IMMUNIZATIONS:
ANTIBIOTIC THERAPY:

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES BCDC GPHL USE ONLY

3. PREVIOUS LABORATORY RESULTS/OTHER INFORMATION

DATE OF REPORT:

FORM GPHL
DPHSS_FRM_05/18/16