



PLACE BARCODE HERE

OLS USE ONLY

FOOD LABORATORY SAMPLE 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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UNSAT

Reason/ID:

ACC:

DE:

CKD:

DATE OF COLLECTION:

TEST REQUESTED:

Note below the type of testing requested.

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)	

COMMENTS: