

COMMONWEALTH OF PENNSYLVANIA	PATIENT NAME LAST FIRST MIDDLE				RETURN TO: BUREAU OF LABORATORIES	
	ADDRESS				PENNSYLVANIA DEPARTMENT OF HEALTH	
	CITY		STATE	ZIP	110 PICKERING WAY	
	PATIENT PHONE #				EXTON, PA 19341	
	DATE OF BIRTH	SEX	ETHNICITY	RACE	OUTBREAK # (IF GIVEN)	FI
	ONSET DATE				SUBMITTER - RESULTS FAXED TO	
	SOURCE OF SPECIMEN			MEDIA SUBMITTED	FACILITY NAME	
	SPECIFIC AGENT SUSPECTED				CONTACT NAME	
	LABORATORY TEST(S) REQUESTED				ADDRESS	
	PLACE PATIENT LABEL HERE ATTACH RESULTS, IF APPLICABLE				CITY, STATE, ZIP	
					EMAIL	
	FORM # H 840.336 REVISED 06-2023				PHONE #	FAX #
				ORDERING HEALTHCARE PROVIDER		
				SPECIMEN SUBMISSION FORM		
				DEPARTMENT OF HEALTH - BUREAU OF LABORATORIES		