

Legionella Test

Patient Information

- Patient Name:
- Date of Birth:
- Medical Record Number:
- Email:
- Phone Number:

Clinical Information

- Reason for Test:
- Symptoms (if any):
- Exposure History:

Specimen Collection

- Sample Type:
- Collection Date and Time:
- Location of Sample Collection:
- Sample Collector's Name:

Laboratory Information

- Laboratory Requisition Number:
- Date Sent to Laboratory:
- Laboratory Contact Information:
- Requested Test Method:

Test Results

- Test Result:
- Date of Test Result:
- Interpretation/Comments:

Follow-up Actions

- **Treatment Initiated (if applicable):**
- **Public Health Notified (if applicable):**
- **Recommendations to Patient:**

Physician's Signature: _____ **Date:** _____