Consult Diagnostic Strep A Throat Swab

Kit Lot #:_____ Exp. Date:_____

Date	Tech		Lot #	Expir Date	Test Result (+, - , invalid)	Control Line (+)(-)	Test Line (+)(-)
		Positive Control					
		Negative Control					

Date	Tech	Last Name	First Name	Chart #:	Test Result (+, -, invalid)	Internal QC (+)(-)	
						Control Line	Test Line

Laboratory Director: _____ Date: _____