STATE LAB

Use Only

Laboratories Administration MDH
1770 Ashland Ave•Baltimore,MD 21205
443-681-3800
http://health.maryland.gov/laboratories/
Robert A. Myers, Ph.D., Director

MARYLAND Department of Health

SEROLOGICAL TESTING

TYPE OR PRINT REQUIRED INFORMATION OR PLACE LABELS ON BOTH COPIES

☐EH ☐FP ☐ MTY/PN ☐NOD ☐ STD/STI ☐ TB ☐ CD ☐ COR
Heath Care Provider/Facility
Address
City County
State Zip Code
Contact Name
Phone # Fax #
Test Request Authorized by

Patient SS # (last 4 digits):
Last Name ☐ SR ☐ JR ☐Other:
First Name M.I.
Date of Birth (mm/dd/yyyy) / /
Address
City County
State Zip Code

Sex: ☐ Male ☐ Female ☐ Transgender M to F ☐ Transgender F to M
Ethnicity: Hispanic or Latino Origin? ☐Yes ☐ No
Race: ☐ American Indian/Alaska Native ☐Asian ☐Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White
MRN/Case # | Dept. of Corrections # | Outbreak # | Submitter Lab#
Date Collected: | Time Collected: ☐a.m. ☐ p.m. | *Vaccination History____ ____ ____ ____
Previous Test Done? ☐ No ☐ Yes
Name of Test _____ Date____/____/____ ☐ 1st ☐2nd☐ 3rd State Lab Number: _____
Name of Test _____ Date____/____/____ ☐ 1st ☐2nd☐ 3rd State Lab Number: _____
Onset Date:__/__/____Exposure Date:_____/__/__ ☐ Clinical Illness/Symptoms: _____

SPECIMEN SOURCE CODE

Arbovirus Panels

MANDATORY: Symptoms,Onset Date, Collection Date Based on information provided, PCR and immunological assays will be performed.

Required Information. Check all that apply:

SYMPTOMS: ☐ Headache ☐ Fever ☐ Stiff Neck ☐ Altered Mental State ☐ Muscle Weakness ☐ Rash
Other _____

IMMUNIZATIONS: ☐ Yellow Fever ☐ Flavivirus

IMMUNOCOMPROMISED? ☐ Yes ☐ No

ILLNESS FATAL? ☐ Yes ☐ No

☐ **Arbovirus Endemic Panel**
DIAGNOSIS: ☐ Aseptic Meningitis ☐ Encephalitis ☐ Other

☐ **Arbovirus Travel-Associated Panel**
TRAVEL HISTORY (Dates and Places)
(REQUIRED)

_____

_____

	Aspergillus
	Chagas disease
	Chlamydia (*group antigen IgG*)
	Coxiella burnetii (*Q Fever*)
	Cryptococcus (antigen)
	Cytomegalovirus (*CMV*)
	Epstein-Barr Virus (*EBV*)
	Hepatitis A Screen(IgM Ab only,acute infection) Call Lab (*443-681-3889*) prior to submitting

SPECIMEN SOURCE CODE

	Hepatitis B Screen (*HBs antigen only*) Prenatal patient? ☐Yes ☐No
	*Hepatitis B Panel: (*HBsAg, HBsAb*)
	*Hepatitis B post vaccine(*HBsAb*)
	Hepatitis C screen (*HCV Ab only*)
	Herpes Simplex Virus (*HSV*) types 1&2
	Legionella
	Leptospira
	MMRV Immunity Screen: [Measles(Rubeola)* Mumps, Rubella, Varicella (Chickenpox) IgG Ab only]
	Mononucleosis – Infectious
	Mumps Immunity Screen*
	Mycoplasma
	Rabies (*RFFIT*) (*List vaccination dates above*)*
	Rubella Immunity Screen*
	Rubeola (*Measles*) Immunity Screen*
	Syphilis
	Tickborne Panel- Anaplasma, Babesia microti, Ehrlichia, Lyme Disease, **Powassan Virus, Rickettsia (Rocky Mountain Spotted Fever, Murine typhus), Tularemia **The results are used for EPIDEMIOLOGICAL purposes and a report will not be issued.
	Toxoplasma
	Varicella Immunity Screen
	VDRL (*CSF only*)
	CDC/Other Test(s) Add'l Specimen Codes _____

Prior arrangements have been made with the following MDH Lab Administration Employee:

_____

* Please Note Vaccination History Above

MUST ALSO MARK A TEST

☐ **Submitted for Surveillance and/or Regulatory Compliance**
(Test Result(s)Report NOT ISSUED)

Surveillance Program (If Applicable):

_____

SPECIMEN SOURCE CODE

RESTRICTED TEST
Pre-approved submitters ONLY.
Submit a separate specimen for HIV.
http://health.maryland.gov/laboratories/

☐ HIV
Country of Origin: _____
Rapid Test: ☐ Reactive ☐ Negative
Date:____/____/____

Specimen stored refrigerated (2°- 8°C) after collection:
☐ Yes ☐ No

Specimen transported on Cold Packs:
☐ Yes ☐ No

Serum/ plasma stored frozen (≤ -20°C) after collection:
☐ Yes ☐ No

☐ HCV RNA
Centrifugation Time: ___:___ ___ a.m. ___ p.m.

Specimen Receipt Temperature (For MDH Lab Use Only)

°C

SPECIMEN SOURCE CODES PLACE CODE IN BOX NEXT TO TEST

B	Blood **Specimen** (5 ml)
CSF	Cerebrospinal Fluid **Sample**
P	Plasma **Specimen**
S	Serum **Specimen** (1 ml per test)
U	Urine **Specimen**

Original

CLINIC CODES

EH – Employee Health
FP – Family Planning
MTY/PN – Maternity/Prenatal
NOD – Nurse of Day
STD/STI – Sexually Transmitted Disease/Infections
TB- Tuberculosis
CD- Communicable Disease
COR – Correctional Facility
Do not mark a box if clinic type does not apply

COMPLETING FORM

Press firmly – two part form

Type or print legibly

Printed labels are recommended

Please place labels on all copies of the form

Print or type the name of the person authorized to order test(s)
(This may be added to the pre-printed label.)

Collection date and time are required by law.
WRITE SPECIMEN CODE in box next to test.
Specimen/samples cannot be processed without a requested test.

VACCINATION HISTORY

List vaccination dates for all Rabies, Hepatitis B and MMRV (**M**umps, **M**easles, **R**ubella and **V**aricella) test requests.

Rabies Vaccination history is required for all **RFFIT** test requests.

HIV TESTING

Include previous HIV Test information in the top section under Previous Test Done.

Submit a separate specimen for HIV testing when multiple tests are ordered on the one form.

Questions/comments on the use of the specimen bags/storage/shipping or completing the form, contact:

Accessioning Unit 443-681-3842 or 443-681-3793

To order collection kits and/or specimen collection supplies:

Contact Information:

Outfit Unit 443-681-3777 or Fax 443-681-3850
E-mail mdhlabs.outfits@maryland.gov

For specific test requirements refer to:
"Guide to Public Health Laboratory Services"
Available Online:
health.maryland.gov/laboratories/Pages/home.aspx

LABELING SPECIMENS/SAMPLES

Printed labels with all required patient information are recommended.

Print patient name, date of birth.
Print date and time the specimen was collected.

DO NOT cover expiration date of collection container.

Write specimen source on the collection container(s).

PACKAGING SPECIMENS FOR TRANSPORT

Never place specimens with different temperature requirements in the same bio-bag.

Review the Test Request Form to verify completeness including that the desired test(s) has/have been marked.

Use a separate bio-bag for each form and each temperature requirement. Place the specimen container in the zip lock portion of the bio-bag and seal it closed. Place the folded Test Request Form in the outside pocket of the bio-bag.

If multiple specimen containers are required for various tests marked on 1 form, place each container in a separate bio-bag to protect it from leakage/breakage of the other containers. Then place them all into an outer bio-bag with the Test Request Form in the pocket.

Verify that all specimen containers have been labeled as described above.

URINE SPECIMENS – REFRIGERATE PACKAGING AND SHIPPING

Double bag urine containers. Include absorbent material in the inner bio-bag and express air before sealing. Place this in a second bio-bag with the folded Test Request Form in the pocket of the outer bio-bag. Transport at refrigerated temperature.