

STATE LAB
Use Only

SEROLOGICAL TESTING

TYPE OR PRINT REQUIRED INFORMATION OR PLACE LABELS ON BOTH COPIES	<input type="checkbox"/> EH <input type="checkbox"/> FP <input type="checkbox"/> MTY/PN <input type="checkbox"/> NOD <input type="checkbox"/> STD <input type="checkbox"/> TB <input type="checkbox"/> CD <input type="checkbox"/> COR		Patient SS # (last 4 digits):		
	Health Care Provider		Last name <input type="checkbox"/> SR <input type="checkbox"/> JR <input type="checkbox"/> Other:		
	Address		First Name M.I.		
	City	County	Date of Birth (mm/dd/yyyy) / /		
	State Zip Code		Address		
	Contact Name:		City County		
	Phone #	Fax #	State Zip Code		
	Test Request Authorized by:				
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender M to F <input type="checkbox"/> Transgender F to M		Ethnicity: Hispanic or Latino Origin? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White				
MRN/Case #	DOC #	Outbreak #	Submitter Lab #		
Date Collected:	Time Collected: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	*Vaccination History _____			
Previous Test Done? <input type="checkbox"/> No <input type="checkbox"/> Yes	Name of Test _____ Date ____/____/____	<input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd	State Lab Number: _____		
	Name of Test _____ Date ____/____/____	<input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd	State Lab Number: _____		
Onset Date: ____/____/____ Exposure Date: ____/____/____		<input type="checkbox"/> Clinical Illness/Symptoms: _____			
↓ SPECIMEN SOURCE CODE		↓ SPECIMEN SOURCE CODE		↓ SPECIMEN SOURCE CODE	
Arbovirus Panels (Serum or CSF) Mandatory: Onset Date, Collection Date and Travel History <input type="checkbox"/> Arbovirus Endemic Panel (WNV, EEE, SLE, LAC) <input type="checkbox"/> Arbovirus Travel-Associated Panel (Chikungunya, Dengue, Zika) Based on information provided PCR and Immunological assays will be performed. Required information, check all that apply: DIAGNOSIS: <input type="checkbox"/> Aseptic Meningitis <input type="checkbox"/> Encephalitis <input type="checkbox"/> Other SYMPTOMS: <input type="checkbox"/> Headache <input type="checkbox"/> Fever <input type="checkbox"/> Stiff Neck <input type="checkbox"/> Altered Mental State <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Rash <input type="checkbox"/> Other: ILLNESS FATAL? <input type="checkbox"/> Yes <input type="checkbox"/> No TRAVEL HISTORY (Dates and Places) _____ _____ IMMUNIZATIONS: Yellow fever? <input type="checkbox"/> Yes <input type="checkbox"/> No Flavivirus? <input type="checkbox"/> Yes <input type="checkbox"/> No IMMUNOCOMPROMISED? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Hepatitis B Screen (HBs antigen only) Prenatal patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> *Hepatitis B Panel: (HBsAg, HBsAb) <input type="checkbox"/> *Hepatitis B post vaccine (HBsAb) <input type="checkbox"/> Hepatitis C screen (HCV Ab only) <input type="checkbox"/> Herpes Simplex Virus (HSV) types 1&2 <input type="checkbox"/> Legionella <input type="checkbox"/> Leptospira <input type="checkbox"/> Lyme Disease <input type="checkbox"/> *MMRV Immunity Screen: [Measles (Rubeola) Mumps, Rubella, Varicella, (Chickenpox) IgG Ab only] <input type="checkbox"/> Mononucleosis – Infectious <input type="checkbox"/> *Mumps Immunity Screen <input type="checkbox"/> Mycoplasma <input type="checkbox"/> Rocky Mountain Spotted Fever (RMSF) <input type="checkbox"/> *Rabies (RFFIT) (*List vaccination dates above) <input type="checkbox"/> *Rubella Immunity Screen <input type="checkbox"/> *Rubeola (Measles) Immunity Screen <input type="checkbox"/> Schistosoma <input type="checkbox"/> Strongyloides <input type="checkbox"/> Syphilis – Previously treated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Toxoplasma <input type="checkbox"/> Varicella Immunity Screen <input type="checkbox"/> VDRL (CSF only) <input type="checkbox"/> CDC/Other Test(s) Add'l Specimen Codes _____		▶▶ LAVENDER TOP TUBE REQUIRED ◀◀ <input type="checkbox"/> Hemoglobin Disorders Blood transfusion? (Last 4 months) <input type="checkbox"/> Yes <input type="checkbox"/> No Prenatal Screen? <input type="checkbox"/> Yes <input type="checkbox"/> No Father of Baby Screen? <input type="checkbox"/> Yes <input type="checkbox"/> No Guardian's Name if patient is a minor: _____ Name of Mother of "at risk" baby: _____	
				RESTRICTED TEST Pre-approved submitters Only Submit a separate specimen for HIV http://health.maryland.gov/laboratories/	
				<input type="checkbox"/> HIV Country of Origin: _____ Rapid Test: <input type="checkbox"/> Reactive <input type="checkbox"/> Negative Date: ____/____/____ Specimen stored refrigerated (2 - 8 °C) after collection: <input type="checkbox"/> Yes <input type="checkbox"/> No Specimen transported on Cold Packs: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Aspergillus <input type="checkbox"/> Babesia microti <input type="checkbox"/> Chagas disease <input type="checkbox"/> Chlamydia (group antigen IgG) <input type="checkbox"/> Coxiella burnetii (Q Fever) <input type="checkbox"/> Cryptococca (antigen) <input type="checkbox"/> Cytomegalovirus (CMV) <input type="checkbox"/> Ehrlichia <input type="checkbox"/> Epstein-Barr Virus (EBV) <input type="checkbox"/> Hepatitis A Screen (IgM Ab only, acute infection) Call Lab (443-681-3889) prior to submitting		Prior arrangements have been made with the following MDH Lab Administration employee: _____ *Please Note Vaccination History Above _____ _____		SPECIMEN SOURCE CODE: PLACE CODE IN BOX NEXT TO TEST B Blood (5 ml) CSF Cerebrospinal Fluid L Lavender Top Tube P Plasma S Serum (1 ml per test) U Urine	

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

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 collection containers when collecting specimens from multiple sites/sources.

COMPLETING FORM
Type or print legibly Printed labels are recommended Place printed labels on all copies of form Press firmly –two part form Collection date is required by law Write collection time when appropriate, test specific
WRITE SPECIMEN CODE in box next to test
Specimens/samples can not be processed without a requested test.

PACKAGING SPECIMENS FOR TRANSPORT
Never place specimens with different temperature requirements in the same biobag
Use one (1) biobag per temperature requirement
Review test request form to ensure all test(s) have been marked
Verify all specimens have been labeled
Place folded request form(s) in outer pouch of biobag
Multiple specimens from the same patient with the same temperature requirements must be packaged together in one (1) biobag

VACCINATION HISTORY
Appropriate for outbreak and epidemiological investigations only
A MDH Outbreak Number is required.
Contact your local health department for a MDH Outbreak Number

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 same form

URINE SPECIMENS – Refrigerate PACKAGING AND SHIPPING
Double bag all urine specimens
Urine specimens require absorbent towel in biobag with specimen (express excess air before sealing)
Place bagged urine specimen in second biobag with all refrigerated specimens from the same patient
Place folded test request form(s) in outer pouch of second bag

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 specimen collection supplies contact: Outfits Unit: 443-681-3777 or 443-681-3776

For Specific Test Requirements Refer to: Guide to Public Health Laboratory Services Available on line:

<https://health.maryland.gov/laboratories/Pages/home.aspx>

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