STATE LAB
Use Only

Laboratories Administration MDH
1770 Ashland Ave • Baltimore, MD 21205
443-681-3800 http://health.maryland.gov/laboratories/
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MARYLAND Department of Health

# SEROLOGICAL TESTING

TYPE OR PRINT REQUIRED INFORMATION OR PLACE LABELS ON BOTH COPIES

☐ EH ☐ FP ☐ MTY/PN ☐ NOD ☐ STD ☐ TB ☐ CD ☐ COR

| | |
|---|---|
| Health Care Provider | |
| 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 # | DOC # | 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 (Serum or CSF)

Mandatory: Onset Date, Collection Date and Travel History

☐ Arbovirus Endemic Panel (WNV, EEE, SLE, LAC)

☐ 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: ☐ Aseptic Meningitis ☐ Encephalitis ☐ Other

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

ILLNESS FATAL? ☐ Yes ☐ No

TRAVEL HISTORY (Dates and Places)

_____

_____

IMMUNIZATIONS: Yellow fever? ☐ Yes ☐ No
Flavivirus? ☐ Yes ☐ No

IMMUNOCOMPROMISED? ☐ Yes ☐ No

☐ Aspergillus
☐ Babesia microti
☐ Chagas disease
☐ Chlamydia (group antigen IgG)
☐ Coxiella burnetii (Q Fever)
☐ Cryptococca (antigen)
☐ Cytomegalovirus (CMV)
☐ Ehrlichia
☐ 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
☐ Lyme Disease
☐ *MMRV Immunity Screen: [Measles (Rubeola) Mumps, Rubella, Varicella, (Chickenpox) IgG Ab only]
☐ Mononucleosis – Infectious
☐ *Mumps Immunity Screen
☐ Mycoplasma
☐ Rocky Mountain Spotted Fever (RMSF)
☐ *Rabies (RFFIT) (*List vaccination dates above)
☐ *Rubella Immunity Screen
☐ *Rubeola (Measles) Immunity Screen
☐ Schistosoma
☐ Stronglyoides
☐ Syphllis – Previously treated? ☐ Yes ☐ No
☐ 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

_____

_____

_____

## ↓ SPECIMEN SOURCE CODE

►► LAVENDER TOP TUBE REQUIRED ◄◄

☐ Hemoglobin Disorders
Blood transfusion? (Last 4 months) ☐ Yes ☐ No
Prenatal Screen? ☐ Yes ☐ No
Father of Baby Screen? ☐ Yes ☐ 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/

☐ HIV

Country of Origin: _____

Rapid Test: ☐ Reactive ☐ Negative

Date: _____/_____/_____

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

Specimen transported on Cold Packs: ☐ Yes ☐ No

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 |

Client

## 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**

## 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.**

## 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

**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 or443-681-3776**

**For Specific Test Requirements Refer to:**
**Guide to Public Health Laboratory Services**
**Available on line:**
**https://health.maryland.gov/laboratories/Pages/home.aspx**

## 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.**

## 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

## 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

## LAB USE ONLY