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 ☐ TB ☐ CD ☐ COR

Health Care Provider **REQUIRED**
Address
City County
State Zip Code
Contact Name:
Phone # Fax #
Test Request Authorized by: **REQUIRED**

Patient SS # (last 4 digits):
Last name ☐ SR ☐ JR ☐ Other:
First Name M.I. **REQUIRED**
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: **REQUIRED** 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: **REQUIRED FOR ARBOVIRUS** ____/____/____ ☐ Clinical Illness/Symptoms: **REQUIRED FOR ARBOVIRUS**

↓ 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)
REQUIRED

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
☐ Syphilis – 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: **REQUIRED**
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