STATE LAB
Use Only

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

MARYLAND
Department of Health and Mental Hygiene

SEROLOGICAL TESTING

TYPE OR PRINT REQUIRED INFORMATION OR PLACE LABELS ON ALL THREE COPIES

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

Health Care Provider	Patient SS# (last 4 digits):
Address	Last Name ☐ SR ☐ JR ☐ Other_____
City County	First Name M.I.
State Zip Code	Date of Birth (mm/dd/yyyy) / /
Contact Name:	Address
Phone# Fax#	City County
Test Request Authorized by:	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: ☐am ☐pm | *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)

Based on information provided PCR and/or 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
- ☐ Chlamydia (group antigen IgG)
- ☐ Cryptococcal (antigen)
- ☐ Cytomegalovirus (CMV)
- ☐ Ehrlichia
- ☐ Epstein-Barr Virus (EBV)
- ☐ Hepatitis A Screen (IgM Ab only, acute infection)
  Call lab (443-681-3889) prior to submitting
- ☐ 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)

⬇ SPECIMEN SOURCE CODE

- ☐ Herpes Simplex Virus (HSV) Types 1&2
- ☐ Legionella
- ☐ Leptospira
- ☐ Lyme Disease
- ☐ *MMRV Immunity Screen: [**M**easles (Rubeola), **M**umps, **R**ubella, **V**aricella (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
- ☐ Strongyloides
- ☐ Syphilis - Previously treated? ☐ yes ☐ no
- ☐ Toxoplasma
- ☐ Tularemia
- ☐ Varicella Immunity Screen
- ☐ VDRL **(CSF only)**
- ☐ CDC/Other Test(s)

Add'l Specimen Codes _____ _____ _____

Prior arrangements have been made with the following DHMH Labs 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
Instructions go to:
http://dhmh.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

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)
UR	**Urine**

Original