

**CONFIDENTIAL REPORT: LABORATORY EVIDENCE OF CERTAIN COMMUNICABLE DISEASES
USE FOR REPORTING TO: MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE**

USE FOR ALL COMMUNICABLE CONDITIONS EXCEPT HIV and CD4. (Use form DHMH 4492 for HIV and CD4.)

(PLEASE TYPE OR PRINT USING BLACK INK.)

PATIENT LAST NAME		FIRST	MIDDLE INITIAL		HOSPITAL NUMBER		PREGNANT? (FEMALE) YES <input type="checkbox"/> NO <input type="checkbox"/>	
DATE OF BIRTH			AGE	SEX	ETHNICITY HISPANIC <input type="checkbox"/> NON-HISPANIC <input type="checkbox"/>		RACE	
NUMBER	STREET	APT	CITY	STATE	ZIP	COUNTY	(AREA CODE) PHONE	
ORDERING PROVIDER		NAME						
NUMBER	STREET	SUITE	CITY	STATE	ZIP	COUNTY	(AREA CODE) PHONE	
(AREA CODE) FAX								
ORDERING FACILITY NAME								
NUMBER	STREET	SUITE	CITY	STATE	ZIP	COUNTY	(AREA CODE) PHONE	
DATE SPECIMEN COLLECTED			DATE SPECIMEN RECEIVED		DATE RESULTED		LAB ACCESSION NUMBER	
TYPE OF SPECIMEN								
Sputum <input type="checkbox"/>		Stool <input type="checkbox"/>		Pharyngeal Swab <input type="checkbox"/>		Discharge <input type="checkbox"/>		
Blood <input type="checkbox"/>		CSF <input type="checkbox"/>		Washing <input type="checkbox"/>		Other (Specify) _____		
SITE OF SPECIMEN (CERVIX, EYE, ETC.)								
NAME OF TEST						TEST NUMBER OR CODE		
RESULT WITH REFERENCE RANGE & INTERPRETATION								
(IF AN ORGANISM RESULT: INCLUDE SPECIES, SEROGROUPING, OR OTHER SUBTYPING IF KNOWN)								
IF A HEPATITIS C RESULT:								
Hep C Antibody (Rapid Test)		Hep C Antibody (ELISA)		Hep C RNA		Hep A IgM		Hep B Core IgM
LAB NAME (LAB PERFORMING THE TEST)						LAB CLIA NUMBER		
LAB ADDRESS								
LAB DIRECTOR			LAB (AREA CODE) PHONE			DATE OF REPORT		

DHMH 1281

SEND TO YOUR LOCAL HEALTH DEPARTMENT

Revised MAY 31, 2017

For more forms or information, go to <http://phpa.health.maryland.gov/Pages/what-to-report.aspx>