MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
LABORATORIES ADMINISTRATION

PLEASE READ – REVISED INSTRUCTIONS

USING THE SEROLOGICAL TESTING FORM TO REQUEST HIV TEST

NOTE: References to the CTR site# and CTR # ID sticker apply ONLY to participants in the statewide CTR System

I. DIRECTIONS FOR COLLECING BLOOD AND LABELING THE SPECIMEN TUBE

Gloves should always be worn when collecting blood from individuals. Use a disposable Vacutainer system to collect blood. Collect 5-7 ml of blood in a red stopper Vacutainer tube and allow blood to clot. All specimen tubes should be labeled with the **patient name. Please affix patient ID labels to the specimen tube.**

IF THE VACUTAINER ADAPTOR AND NEEDLE ARE NOT AVAILABLE FOR COLLECTION OF BLOOD:
Use only disposable syringes and needles to collect blood. Transfer blood to Vacutainer tube by inserting the needle through the stopper and allowing the tube vacuum to pull the blood from the syringe into the tube.

DO NOT REMOVE THE STOPPER FROM THE VACUTAINER TUBE OR FORCE BLOOD INTO THE TUBE. If the stopper is removed, it cannot be replaced securely for transport. DO NOT ATTEMPT TO REMOVE THE NEEDLE FROM THE SYRINGE OR BEND/CUT THE NEEDLE PRIOR TO DISPOSAL.

II. FILLING OUT LAB REQUEST SLIP

Please provide all available information on the lab request form. **For submitter information refer to Comment Boxes A and B on the sample form. For patient information refer to Comment Box C. If a CTR ID number sticker was used on the specimen tube then place the same label on the lab request form, refer to Comment Box D.** Include both the date and time of specimen collection on lab request form**; refer to Comment Box E**. Indicate if this is an initial test or follow-up test by marking 1st specimen or 2nd specimen respectively. Include previous test information in designated area of the form. **CTR sites should provide the site #; refer to Comment Box F.** The last copy of the Serological Testing Form should be retained at the collection site.

Use printed patient ID labels whenever possible on both the lab request form and specimen tube to ensure the spelling of the patient name and patient ID numbers match exactly.

HIV SECTION OF THE SEROLOGICAL TESTING FORM (See red outlined area and refer to Comment Box G)

III. SUBMITTING SPECIMENS

The DHMH Laboratories Administration has approved the use of bio-bags for the transport of HIV specimens via courier when the blood has been collected in a **plastic** vacutainer tube. **DO NOT** transport **glass** vacutainer tubes in bio-bags. Place specimen tube into the inner pocket of the bio-bag and securely seal the bag, then place the lab request form in the outer pocket of the bio-bag.
ONLY ONE SPECIMEN TUBE SHOULD BE SUBMITTED PER SINGLE BIO-BAG. DO NOT BUNDLE, SECURE WITH RUBBER BANDS, TAPE OR STAPLE THE BIO-BAGS.

When transporting through US Mail, UPS or FEDEX, federally approved Biohazard packaging must be used (refer to U.S. Postal Service Regulations, Department of Transportation Regulations and International Air Transport Association Regulations).

Acceptance criteria for HIV Testing: Specimens **must be received within 3 days** if stored and shipped at room temperature or **7 days if stored refrigerated and shipped on cold packs/ in cooler**. Specimens should be stored refrigerated whenever possible and submitted for testing immediately after collection to ensure a satisfactory test specimen. Record specimen storage and transport conditions on the Serological Testing Form in the designated **HIV Section outlined in red and refer to Comment Box G. A separate specimen must be submitted for HIV testing.**
SPECIMENS GREATER THAN 7 DAYS ARE UNACCEPTABLE FOR TESTING.

STATE LAB
Use Only

Laboratories Administration MD DHMH
443-[illegible] 1205
[illegible]boratories/
[illegible]r

MARYLAND

A. Complete fields of the submitter information section or place preprinted submitter information label here.

C. Complete fields of the patient information section or place preprinted patient ID label here.

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:	Zip Code
Sex: ☐ Male ☐ Female ☐ Transgender M to F [illegible]	[illegible]gin? ☐ yes ☐ no
Race: ☐ American Indian/Alaska Native ☐ A	[illegible]r Pacific Islander ☐ White
MRN/Case # DOC #	[illegible]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:_____	

B. Fill in the TRAB box or include on your label/stamp the name/credentials of the authorized provider ordering the test.

E. Collection date and time must be entered.

⬇ SPECIMEN SOURCE CODE

Arbovir
Mandatory: Onset

- ☐ 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: [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
- ☐ Strongyloides
- ☐ Syphilis - Previously treated? ☐ yes ☐ no
- ☐ Toxoplasma
- ☐ Tularemia

G. Must submit separate specimen and write specimen code (B or S) next to HIV test order. **Note X or check marks are not acceptable.**

Prior arrangements have been made with the following DHMH Labs Administration employee: _____

F. Write CTR Site# here.

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/

- B ☐ 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**

D. Place CTR ID# Sticker here.

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Original

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
Write the person's name that is authorized to order test in the box provided
Press **firmly** - three part form
Collection date & time are required by Law
WRITE SPECIMEN CODE in box next to test
***Specimens/samples can not be processed without a requested test.**

VACCINATION HISTORY

List vaccination dates for all Rabies, Hepatitis B and MMRV (Mumps, Measles, Rubella, and Varicella) test request.
Rabies Vaccination history is required for all RFFIT test requests.

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 one 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 collection kits and/or specimen collection supplies, contact:
Outfit Unit 443-681-3777 or Fax 443-681-3850

For Specific Test Requirements Refer to:
"Guide to Public Health Laboratory Services"
Available on line: dhmh.maryland.gov/laboratories

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 container(s)

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