

Rabies Antibody Titer (RFFIT) Test Submission Guidelines for Maryland Residents Not Employed by the State or Local Health Departments (LHDs)

Effective January 1, 2014

I. RFFIT COLLECTION KIT

To request a RFFIT collection kit, contact the MDH Laboratories Administration Outfit Room at (443) 681-3777. Alternatively, a kit request form can be downloaded at <http://www.health.maryland.gov/laboratories/SitePages/rabies.aspx>, and completed then faxed to (443) 681-3850.

- A. The RFFIT collection kit includes the following:
- Serological Testing MDH-4677 Form (submission form)
 - Red Top Tube
 - Biohazard Bag (6x9)
 - Bubble Wrap
 - RFFIT Specimen Submission Guideline
- B. For RFFIT test specific questions, contact the MDH Rabies Laboratory at (443) 681-3773.
- C. The MDH Laboratories Administration Outfit Room will ship the RFFIT collection kits to the address provided on the Kit Request Form.
- D. A healthcare provider authorized to request medical laboratory tests listed below MUST authorize the RFFIT test.
- | | |
|---|---|
| M.D. (Doctor of Medicine) | D.D.S. (Doctor of Dental Surgery) |
| D.M.D. (Doctor of Dental Medicine) | P.A. (Certified Physician Assistant) |
| C.R.N.P (Certified Registered Nurse Practitioner) | N.P. (Nurse Practitioner) |
| C.F.N.P (Certified Family Nurse Practitioner) | D.O. (Doctor of Osteopathic Medicine) |
| M.S.W.C (Master of Social Work Clinical) | D.S.W.C. (Doctor of Social Work Clinical) |

II. SPECIMEN SUBMISSION INSTRUCTIONS

For appropriate submission, follow the steps below.

- A. On the Serological Testing MDH-4677 Form (submission form), the name of the healthcare provider authorized to request medical laboratory tests (see list above) MUST be entered in the Test Request Authorized section. Ensure submitter name, address, phone no., and a FAX NO. (fax no. required to receive the test report), are correctly and legibly completed on the submission form. (see completed submission form example attached).
- B. Draw the blood using a red top tube. (3-5ml of whole blood is required).
- C. Label the red top tube with the following information:
- Last Name, First Name
 - Date of Birth
 - Collection Date
 - Attach a barcode label located at the bottom of the Serological Testing form to the red top tube.
- D. Place the labeled red top tube in the bubble wrap, and then put it in the biohazard bag.
- E. Seal the biohazard bag (one specimen per bag).

- F. Place the completed Serological Testing MDH-4677 Form in the outside pocket of the biohazard bag.

Note: Specimens may be stored in the refrigerator (2-8°C), but not more than 3 days before shipping. Inappropriate submissions may result in a delay of testing and or rejection of the submission.

III. PAYMENT

- A. A check for \$60 must be enclosed for each specimen submission. If you are submitting more than one specimen, please include a check for the total number of specimens.
- B. Make checks payable to the MDH-Laboratories Administration.
- C. The completed check MUST be enclosed with the specimen shipment.
- D. Contact MDH Laboratories Administration Fiscal Unit (443-681-3815) for billing inquiries.

IV. SHIPPING

- A. Specimens can be sent to the MDH Rabies laboratory using the following methods:
- Local couriers (shipper is responsible for the cost of shipping).
 - Drop-off at the receiving area of the laboratories administration.
 - Drop-off at your local health department. However, you MUST call the Administrative Officer (443-681-3820) to make initial arrangements and get the information for the drop-off location.
 - An overnight courier such as FEDEX, UPS, or USPS can be used Monday–Thursday only. (Compliance to IATA regulations is required). NOTE: Certified packaging systems are not supplied by the Laboratories Administration. The shipper is responsible for the cost of shipping.
- B. Ship specimens in insulated containers with ice packs. DO NOT use wet ice or dry ice. Also, animal rabies-DFA and RFFIT specimens CANNOT be shipped in the same container.
- C. Ship to:
- Maryland Department of Health Laboratories Administration
Attention: ACCESSIONING RABIES/RFFIT TITER TESTING
1770 Ashland Avenue
Baltimore, MD 21205

V. TEST REPORT

The test report will be faxed to the fax number provided on the submission form. Please ensure that you provide a functional fax no.

For additional information, please contact the Rabies-Zoonotic Diseases Program at (443) 681-3773.
<http://www.health.maryland.gov/laboratories/SitePages/rabies.aspx>

Rabies Antibody Titer (RFFIT) Test Submission (01/28/2014)



Laboratories Administration MD DHMH
 201 W. Preston St. • Baltimore, MD 21201
 P.O. Box 2355 • Baltimore, MD 21203-2355
 410-767-6100 <http://dhhm.maryland.gov/laboratories/>
 Robert A. Myers, Ph.D., Director

STATE LAB
 Use Only

SEROLOGICAL TESTING

Must complete submitter information & include name of the authorized person requesting the test.

Fill in a functional fax number (required to receive the test report).

Fill in the date when specimen was collected.

Patient's First & Last Names and Date of Birth must also be on the red top tube and should exactly match the submission form.

List month/year rabies vaccination was/were received.

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

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

Patient SS# (last 4 digits):
 Last Name First Name M.I. Maiden:
 Date of Birth (mm/dd/yyyy) / /
 Address City County State Zip Code

Sex: Male Female Transgender M to F Transgender F to M
 Race: American Indian/Alaska Native Asian Black/African American Native Hawaiian/other Pacific Islander White
 Collect Date: / / Collect Time: : : Date of Vaccination: / /
 Previous Test Done? No Yes Date: / /
 Onset Date: / / Exposure Date: / /
 Clinical Illness/Symptoms

DOC# Outbreak # Submitter Lab #

Specimen Code: B or S
 *Rabies (RFFIT) (*List vaccination dates above)
 Rubella Immunity Screen
 *Rubella (Measles) Immunity Screen
 Syphilis: Previously treated? Yes No
 Toxoplasma
 Tularemia
 Varicella Immunity Screen
 VDRL (CSF only)
 CDC/Other Test(s)

Specimen 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: _____

Specimen Code: B or S
 Blood (5 ml)
 CSF Cerebrospinal Fluid
 L Plasma
 P Plasma
 S Serum (1 ml per test)
 UR Urine

Barcode: 77924324

ORIGINAL

Use only the B or S specimen code.

Attach a barcode label to the red top tube

Inappropriate submissions may result in a delay of testing and or rejection of the submission. For questions, please contact the Rabies/Zoonotic Diseases Program at (410) 767-6177. Additional information are posted on the rabies laboratory website. <http://www.dhmm.maryland.gov/laboratories/SitePages/rabies.aspx>



MARYLAND DEPARTMENT OF HEALTH

LABORATORIES ADMINISTRATION
1770 ASHLAND AVENUE BALTIMORE, MD 21205
PHONE: 443-681-3776 or 443-681-3777
FAX: 443-681-3850

Outfit Supply Requisition

SUBMITTER: _____ **DATE:** _____

NAME OF FACILITY: _____ **PHONE:** _____

ADDRESS: _____

<u>KITS</u>	<u>QUANTITY</u>	<u>COMPONENTS</u>	<u>QUANTITY</u>
1. PINWORM SLIDES	_____	8. BIOHAZARD BAGS	_____
2. FLOW CYTOMETRY	_____	9. GC PLATES <input type="checkbox"/> BAGS <input type="checkbox"/> PILLS <input type="checkbox"/> SWABS	_____
3. VIRAL CULTURE KIT	_____	10. MISCELLANEOUS URINE CUPS	_____
4. SPUTUM (T B CULTURE)	_____	11. RED TOP TUBES	_____
5. VIRAL LOAD KIT	_____	12. LAVENDER TUBES	_____
6. GENO TYPING KIT	_____	13. BLOOD CULTURE	_____
7. RFFIT COLLECTION KIT	_____	14. ENTERIC PATHOGEN MEDIA (PARA PAK C&S)	_____
CHLAMYDIA/GORNORRHEA NAAT		15. INTESTINAL PARASITE MEDIA (PARA PAK ECO, O&P)	_____
VAGINAL SPECIMEN TRANS KIT	_____	16. CHLAMYDIA CELL CULTURE MEDIA	_____
UNISEX SWAB KIT	_____	17. STUART'S TRANSPORT MEDIA	_____
URINE KIT	_____	18. AMIES TRANSPORT MEDIA	_____
URINE CUPS	_____	FORMS 100 PER PACK	
TUBES	_____	1. INFECTIOUS AGENTS/CULTURE/DETECTION-DHMH 4676	_____
PIPETTES	_____	2. SEROLOGICAL TESTING DHMH 4677	_____
CAPS	_____	3. ENVIRONMENTAL FORM DHMH#	_____
		4. FLOW CYTOMETRY DHMH 4393	_____
		5. VIRAL LOAD DHMH 4393-A	_____
		6. OTHER	_____