Laboratories Administration MD DHMH
201 W. Preston St. • Baltimore, MD 21201
P.O. Box 2355 • Baltimore MD, 21203-2355
410-767-6100 www.dhmh.state.md.us/labs
John M. DeBoy, Dr. P. H., Director

STATE LAB Use Only

SEROLOGICAL TESTING

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

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

Submitter

Address

City County

State Zip Code

Contact Name

Phone # Fax #

Patient SS# (last 4 digits):

Last Name ☐SR ☐JR ☐Other

First Name M.I. Maiden:

Date of Birth (mm/dd/yyyy) / /

Address

City County

State Zip Code

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Unknown

Sex: ☐Male ☐Female ☐Transgender

Race: ☐White ☐African American ☐Asian/Pacific ☐American Indian/Alaska Native ☐Multiracial ☐Not specified ☐Other

Case # DOC# Outbreak # Submitter Lab #

Collect Date: Collect Time: ☐am ☐pm *Rabies Vaccination Dates:

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:

SEROLOGY: SERUM (1ml/test) or WHOLE BLOOD (5ml) REQUIRED

☐ Arbovirus / West Nile Virus Panel
(Serum or CSF)
Provide dates of onset & collection (see above)
Required information, check all that apply:
DIAGNOSIS:☐aseptic meningitis ☐encephalitis
☐fever ☐other
SYMPTOMS: ☐headache ☐fever ☐stiff neck
☐altered mental status ☐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
☐ Brucella
☐ Chlamydia (group antigen IgG)
☐ Cryptococcal antigen
☐ Cytomegalovirus (CMV)
☐ *E. histolytica*
☐ Ehrlichia
☐ Epstein-Barr Virus (EBV)
☐ Hepatitis A Screen (IgM Ab only, acute infection)
Call lab (410-767-6169) prior to submitting
☐ Hepatitis B Screen (HBs antigen only)
Prenatal patient? ☐yes ☐no
☐ Hepatitis B Panel: (HBsAg, HBsAb)
Reflex Testing: HBsAb Neg HB Total Core
HBsAg Pos: HB Core IgM, HBeAg, HBeAb
☐ Hepatitis B post vaccine
☐ Hepatitis C screen (HCV Ab only)

☐ 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
☐ Syphilis - Previously treated? ☐yes ☐no
☐ Toxoplasma
☐ Tularemia
☐ Varicella Immunity Screen
☐ VDRL **(CSF only)**
☐ CDC test request
Call lab (410-767-6162) prior to submitting
Test requested:
☐ Other test request:

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

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 father of "at risk" baby:

☐ Lead, Blood
Patient hospitalized? ☐yes ☐no
Chelation therapy? ☐yes ☐no
Guardian's name if patient is a minor:
Patient's phone number:

SPECIMEN CODE:
PLACE CODE IN BOX NEXT TO TEST

B	**Blood**
CSF	**Cerebrospinal Fluid**
L	**Lavender Top Tube**
P	**Plasma**
S	**Serum**
UR	**Urine**

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DHMH 4677 Revised 10/08

ORIGINAL

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