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| **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 🞎 NO 🞎 | |
| DATE OF BIRTH | | | | | | AGE | SEX | | ETHNICITY  HISPANIC 🞎 NON-HISPANIC 🞎 | | |  | | | | 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 🞎 | Stool 🞎 | | | Pharyngeal Swab 🞎 | | | | | | | Discharge 🞎 | | | | | | | |
| Blood 🞎 | CSF 🞎 | | | Washing 🞎 | | | | | | | 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>