STATE LAB
Use Only

Laboratories Administration MDH
1770 Ashland Ave•Baltimore,MD 21205
443-681-3800 http://health.maryland.gov/laboratories/
Robert A. Myers, Ph.D., Director

MARYLAND
Department of Health

SEROLOGICAL TESTING

TYPE OR PRINT REQUIRED INFORMATION OR PLACE LABELS ON

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

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

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

Sex: ☐ Male ☐ Female ☐ Transgender M to F ☐ Transgender F to M
Ethnicity: Hispanic or Latino Origin? ☐Yes ☐ No
Race: ☐ American Indian/Alaska Native ☐Asian ☐Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White
MRN/Case # DOC # Outbreak # Submitter Lab #
Date Collected: REQUIRED Time Collected: ☐a.m. ☐ p.m. *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 REQUIRED FOR ARBOVIRUS / /
☐ Clinical Illness/Symptoms: REQUIRED FOR ARBOVIRUS

SPECIMEN SOURCE CODE

Arbovirus Panels (*Serum or CSF*)
Mandatory: Onset Date, Collection Date and Travel History

☐ Arbovirus Endemic Panel (*WNV, EEE, SLE, LAC*)
☐ Arbovirus Travel-Associated Panel (Chikungunya, Dengue, Zika)

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)
REQUIRED

IMMUNIZATIONS: Yellow fever? ☐ Yes ☐ No
Flavivirus? ☐ Yes ☐ No

IMMUNOCOMPROMISED? ☐ Yes ☐ No

☐ Aspergillus
☐ Babesia microti
☐ Chagas disease
☐ Chlamydia (*group antigen IgG*)
☐ Coxiella burnetii (*Q Fever*)
☐ 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

SPECIMEN SOURCE CODE

☐ 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*)
☐ 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
☐ Rabies (*RFFIT*) (*List vaccination dates above*)*
☐ Rickettsia (*Rocky Mountain Spotted Fever*)
☐ Rickettsia (*Murine Typhus*)
☐ Rubella Immunity Screen*
☐ Rubeola (*Measles*) Immunity Screen*
☐ Schistosoma
☐ Strongyloides
☐ Syphilis – Previously treated? ☐ Yes ☐ No
☐ Toxoplasma
☐ Varicella Immunity Screen
☐ VDRL (*CSF only*)
☐ CDC/Other Test(s)
Add'l Specimen Codes ____________

Prior arrangements have been made with the following MDH Lab Administration Employee:

____

***Please Note Vaccination History Above**

SPECIMEN SOURCE CODE

RESTRICTED TEST
Pre-approved submitters Only
Submit a separate specimen for HIV
http://health.maryland.gov/laboratories/

☐ 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 CODES:
PLACE CODE IN BOX NEXT TO TEST

B	**Blood** (5 ml) REQUIRED
CSF	**Cerebrospinal Fluid**
P	**Plasma**
S	**Serum**(1 ml per test)
U	**Urine**

Original