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 OIR PRINT REQUIRED INFORMATION OR PLACE LABELS ON BOTH COPIES

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

Provider	Patient
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:	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: | 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: ____/____/_____ Exposure Date: ____/____/_____ ☐ Clinical Illness/Symptoms: ______________________________

↓ 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 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
☐ Babesia microti
☐ Chagas disease
☐ Chlamydia (group antigen IgG)
☐ Coxiella burnetii (Q Fever)
☐ Cryptococca (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
☐ Rocky Mountain Spotted Fever (RMSF)
☐ *Rabies (RFFIT) (*List vaccination dates above)
☐ *Rubella Immunity Screen
☐ *Rubeola (Measles) Immunity Screen
☐ Schistosoma
☐ Stronglyoides
☐ Syphllis – 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

►► 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
http://health.maryland.gov/laboratories/

☐ HIV

Country of Origin: ____________________

Rapid Test: ☐ Reactive ☐ Negative

Date: ________/________/________

Specimen stored refrigerated (2 - 8 ℃) after collection: ☐ Yes ☐ No

Specimen transported on Cold Packs: ☐Yes ☐ No

SPECIMEN SOURCE CODE:
PLACE CODE IN BOX NEXT TO TEST

Code	Specimen
B	**Blood** (5 ml)
CSF	**Cerebrospinal Fluid**
L	**Lavender Top Tube**
P	**Plasma**
S	**Serum** (1 ml per test)
U	**Urine**

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
Print labels are recommended
Please print labels on all copies of form
Write the person's name that is authorized to order test in the box provided
Press firmly – two part form
Collection date and time are required by Law.
WRITE SPECIMEN CODE in box next to test
***Specimen/samples cannot 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 online: mdh.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 the 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.