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

Health Care Provider
Address
City
State
Contact Name:
Phone #
Test Request Authorized by:

Must complete the Health Care Provider information(this is where reports will be sent). Include the name of Healthcare provider who can legally order the test(s) in "Test Request Authorized by" box.

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

Patient first & last name must be on specimen container & exactly match the lab slip

Sex: ☐ Male ☐ Female ☐ ...der 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
Date ___/___/___ ☐ 1st ☐ 2nd ☐ 3rd State Lab Number: ________
Date ___/___/___ ☐ 1st ☐ 2nd ☐ 3rd State Lab Number: ________

Collection date & Onset of symptoms date **MUST** be included.

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
☐ ...ty Screen
☐ ...
☐ ...Spotted Fever (RMSF)
☐ ...(*List vaccination dates above)
☐ ...ty Screen
☐ ...es) Immunity Screen
☐ Schistosoma
☐ Stronglyoides
☐ Syphllis – Previously treated? ☐ Yes ☐ No
☐ Toxoplasma
☐ Varicella Immunity Screen
☐ VDRL (CSF only)
☐ CDC/Other Test(s)
Add'l Specimen Codes ______ ______ ______

Patient travel history (locations and dates), symptoms, vaccination history and immune status MUST be included.

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 ☐ ...

Specimen transported on Cold Pa...

SPECIMEN SOURCE CODE:
PLACE CODE IN BOX NEXT TO ...

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

Indicate **S** for SST, serum aliquot, or whole clotted blood (red-top)
U for urine (leak proof sterile urine cup), **L** for whole unclotted blood **UNSPUN** (purple top), **CSF** for cerebrospinal fluid (leak proof sterile container).
***Urine, CSF, and whole blood must be submitted with an accompanying serum specimen.**