

SPECIAL SEROLOGY

N.C. Department of Health and Human Services
 State Laboratory of Public Health
 4312 District Drive • P.O. Box 28047
 Raleigh, NC 27611-8047

Please Give All Information Requested

Attach Printed Label Below

Patient Information	Last Name			
	First Name	MI		
	Maiden Name/Surname			
	Address/Attention:			
	Street Address:		Address 2:	City:
	State:	Zip Code:	County Code:	County Name:
	SSN: _____/_____/_____	Medicaid Number (if applicable): _____		
	Medical Record Number:	Date of Birth: _____/_____/_____	If Female, Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Transgender M2F <input type="checkbox"/> Female <input type="checkbox"/> Transgender F2M <input type="checkbox"/> Unknown <input type="checkbox"/> Transgender Unknown <input type="checkbox"/> Ambiguous	Race (mark all that apply): <input type="checkbox"/> White <input type="checkbox"/> American Indian/ <input type="checkbox"/> Black <input type="checkbox"/> Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/ <input type="checkbox"/> Unknown <input type="checkbox"/> Pacific Isles		Ethnicity: <input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	
Submitter	EIN: _____-_____-_____		Submitter Name:	
	Address:		Address 2:	City:
	State:		Zip Code:	County Name:
	Phone Number:		Email Address:	Fax Number:
	Ordering Provider NPI:		Ordering Provider First and Last Name:	
Specimen (continued on page 2)	Specimen source(s):	Collection Date(s):	Collector's Initials:	Laboratory Number(s): <i>Do Not Write in this Space</i>
	<input type="checkbox"/> Acute Serum <i>(within 7 days of onset)</i>	_____/_____/_____		
	<input type="checkbox"/> Convalescent Serum	_____/_____/_____		
	<input type="checkbox"/> Whole Blood	_____/_____/_____		
	<input type="checkbox"/> CSF	_____/_____/_____		
	<input type="checkbox"/> Urine	_____/_____/_____		
	<input type="checkbox"/> Amniotic Fluid	_____/_____/_____		
	Onset Date: _____/_____/_____			Reason for Testing (ICD-10 Dx Code): _____
Serologic Diagnostic Panels Available: <i>(Check one or more boxes, as needed)</i>				
<input type="checkbox"/> Arboviral Panel (Eastern Equine Encephalitis, Western Equine Encephalitis, St. Louis Encephalitis, La Crosse Encephalitis, and West Nile)				
<input type="checkbox"/> Rickettsia Panel (<i>Rickettsia rickettsii</i> , <i>Rickettsia typhi</i> , <i>Ehrlichia</i> species)				

Specimen (continued from page 1)	Exanthems: (All suspect cases must be approved for testing by the Communicable Disease Branch (CDB) prior to submission of specimen to the State Lab. CDB can be reached at 919-733-3419.) <input type="checkbox"/> Measles, Rubella <input type="checkbox"/> Varicella Zoster, IgG <input type="checkbox"/> Mumps, IgG																																																	
	Single Agent Diagnostic Tests: (Check one or more boxes, as needed) <input type="checkbox"/> Q Fever <input type="checkbox"/> Chikungunya <input type="checkbox"/> Zika **The Physician Attestation (below) must be signed prior to testing.** <input type="checkbox"/> Other: _____ <input type="checkbox"/> Prior approval/consultation received from: _____ <input type="checkbox"/> Please forward specimen to CDC for testing. (Attach a completed CDC 50.34 DASH form).																																																	
Other Patient Information	Patient Signs and Symptoms: <i>(Check all that apply)</i> <table style="width:100%; border: none;"> <tr> <td style="width: 20%;">General</td> <td style="width: 20%;">Rash</td> <td style="width: 20%;">Respiratory</td> <td style="width: 20%;">CNS</td> <td style="width: 20%;">Cardiovascular</td> </tr> <tr> <td><input type="checkbox"/> Fever to ___°F</td> <td><input type="checkbox"/> Macular</td> <td><input type="checkbox"/> Cough</td> <td><input type="checkbox"/> Seizures</td> <td><input type="checkbox"/> Chest Pain</td> </tr> <tr> <td><input type="checkbox"/> Headache</td> <td><input type="checkbox"/> Papular</td> <td><input type="checkbox"/> Pneumonia</td> <td><input type="checkbox"/> Meningitis</td> <td><input type="checkbox"/> Pericarditis</td> </tr> <tr> <td><input type="checkbox"/> Fatigue</td> <td><input type="checkbox"/> Vesicular</td> <td><input type="checkbox"/> Bronchitis</td> <td><input type="checkbox"/> Encephalitis</td> <td><input type="checkbox"/> Myocarditis</td> </tr> <tr> <td><input type="checkbox"/> Sore Throat</td> <td><input type="checkbox"/> Petechial</td> <td><input type="checkbox"/> Croup</td> <td><input type="checkbox"/> Nuchal rigidity</td> <td><input type="checkbox"/> Pleurodynia</td> </tr> <tr> <td><input type="checkbox"/> Jaundice</td> <td><input type="checkbox"/> Focal</td> <td><input type="checkbox"/> Pharyngitis</td> <td><input type="checkbox"/> Paralysis</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Conjunctivitis</td> <td><input type="checkbox"/> Hemorrhagic</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Arthralgia/Myalgia</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Nausea/Vomiting</td> <td></td> <td></td> <td></td> <td></td> </tr> </table> <p style="text-align: right; margin-top: 10px;"><i>If pregnant, due date: ___/___/_____</i></p>					General	Rash	Respiratory	CNS	Cardiovascular	<input type="checkbox"/> Fever to ___°F	<input type="checkbox"/> Macular	<input type="checkbox"/> Cough	<input type="checkbox"/> Seizures	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Headache	<input type="checkbox"/> Papular	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Pericarditis	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Vesicular	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Encephalitis	<input type="checkbox"/> Myocarditis	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Petechial	<input type="checkbox"/> Croup	<input type="checkbox"/> Nuchal rigidity	<input type="checkbox"/> Pleurodynia	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Focal	<input type="checkbox"/> Pharyngitis	<input type="checkbox"/> Paralysis		<input type="checkbox"/> Conjunctivitis	<input type="checkbox"/> Hemorrhagic				<input type="checkbox"/> Arthralgia/Myalgia					<input type="checkbox"/> Nausea/Vomiting				
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Recent Vaccination History: _____ _____ _____		Travel History: Area(s): _____ _____ Dates: _____																																																
Physician Attestation for Zika Testing	Zika virus assays are intended for use with specimens collected from individuals meeting CDC Zika virus clinical criteria (e.g., clinical signs and symptoms associated with Zika virus infection) and/or CDC Zika virus epidemiological criteria (e.g., history of residence in or travel to a geographic region with active Zika transmission at the time of travel, or other epidemiologic criteria for which Zika virus testing may be indicated as part of a public health investigation). NCSLPH provides testing to patients when the following criteria are met: <ul style="list-style-type: none"> • A pregnant woman who: <ul style="list-style-type: none"> ➢ Spent time in an area with a Zika travel notice while pregnant, or ➢ Had unprotected sex with a partner who spent time in an area with a Zika travel notice • An individual with symptoms associated with Zika virus infection (rash, joint pain, fever, and/or conjunctivitis) who: <ul style="list-style-type: none"> ➢ Spent time in an area with a Zika travel notice, or ➢ Had unprotected sex with a partner who spent time in an area with a Zika travel notice <input type="checkbox"/> I certify that the patient I am requesting Zika testing for meets the criteria outlined above.*																																																	
	Physician Name (Print) _____ Physician Signature _____ <p style="text-align: center;">* For further guidance regarding eligibility for Zika testing, please visit the Zika Virus Testing page on the NCSLPH website at http://slph.ncpublichealth.com/zika/default.asp</p>																																																	