

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
SEROLOGICAL TESTING



MARYLAND
 Department of Health

TYPE OR PRINT REQUIRED INFORMATION OR PLACE LABELS ON BOTH COPIES	<input type="checkbox"/> EH <input type="checkbox"/> FP <input type="checkbox"/> MTY/PN <input type="checkbox"/> NOD <input type="checkbox"/> STD/STI TB <input type="checkbox"/> CD <input type="checkbox"/> COR		Patient SS # (last 4 digits):	
	Health Care Provider/Facility		Last Name <input type="checkbox"/> SR <input type="checkbox"/> JR <input type="checkbox"/> Other:	
	Address		First Name M.I.	
	City County		Date of Birth (mm/dd/yyyy) / /	
	State Zip Code		Address	
	Contact Name		City County	
	Phone # Fax #		State Zip Code	
	Test Request Authorized by			
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender M to F <input type="checkbox"/> Transgender F to M		Ethnicity: Hispanic or Latino Origin? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White			
MRN/Case #	Dept. of Corrections #	Outbreak #	Submitter Lab #	
Date Collected:	Time Collected: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	*Vaccination History _____		
Previous Test Done? <input type="checkbox"/> No <input type="checkbox"/> Yes	Name of Test _____ Date ____/____/____	<input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd	State Lab Number: _____	
	Name of Test _____ Date ____/____/____	<input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd	State Lab Number: _____	
Onset Date: ____/____/____ Exposure Date: ____/____/____		<input type="checkbox"/> Clinical Illness/Symptoms: _____		

<p>↓ SPECIMEN SOURCE CODE</p> <p>Arbovirus Panels MANDATORY: Symptoms, Onset Date, Collection Date Based on information provided, PCR and immunological assays will be performed.</p> <p>Required Information. Check all that apply:</p> <p>SYMPTOMS: Headache Fever Stiff Neck Altered Mental State Muscle Weakness Rash Other _____</p> <p>IMMUNIZATIONS: Yellow Fever Flavivirus</p> <p>IMMUNOCOMPROMISED? Yes No</p> <p>ILLNESS FATAL? Yes No</p> <p>Arbovirus Endemic Panel DIAGNOSIS: Aseptic Meningitis Encephalitis Other</p> <p>Arbovirus Travel-Associated Panel TRAVEL HISTORY (Dates and Places) (REQUIRED)</p> <p>_____</p> <p>_____</p>	<p>↓ SPECIMEN SOURCE CODE</p> <p><input type="checkbox"/> Hepatitis B Screen (<i>HBs antigen only</i>) Prenatal patient? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> *Hepatitis B Panel: (<i>HBsAg, HBsAb</i>) <input type="checkbox"/> *Hepatitis B post vaccine (<i>HBsAb</i>) <input type="checkbox"/> Hepatitis C screen (<i>HCV Ab only</i>)</p> <p><input type="checkbox"/> Herpes Simplex Virus (<i>HSV</i>) types 1&2</p> <p><input type="checkbox"/> Legionella</p> <p><input type="checkbox"/> Leptospira</p> <p><input type="checkbox"/> MMRV Immunity Screen: [Measles (Rubeola)* Mumps, Rubella, Varicella (Chickenpox) IgG Ab only]</p> <p><input type="checkbox"/> Mononucleosis – Infectious</p> <p><input type="checkbox"/> Mumps Immunity Screen*</p> <p><input type="checkbox"/> Mycoplasma</p> <p><input type="checkbox"/> Rabies (<i>RFFIT</i>) (<i>List vaccination dates above</i>)*</p> <p><input type="checkbox"/> Rubella Immunity Screen*</p> <p><input type="checkbox"/> Rubeola (<i>Measles</i>) Immunity Screen*</p> <p><input type="checkbox"/> Syphilis</p> <p><input type="checkbox"/> Tickborne Panel- Anaplasma, Babesia microti, Ehrlichia, Lyme Disease, **Powassan Virus, Rickettsia (Rocky Mountain Spotted Fever, Murine typhus), Tularemia</p> <p>**The results are used for EPIDEMIOLOGICAL purposes and a report will not be issued.</p> <p><input type="checkbox"/> Toxoplasma</p> <p><input type="checkbox"/> Varicella Immunity Screen</p> <p><input type="checkbox"/> VDRL (<i>CSF only</i>)</p> <p><input type="checkbox"/> CDC/Other Test(s) Add'l Specimen Codes _____</p> <p>Prior arrangements have been made with the following MDH Lab Administration Employee: _____</p> <p>* Please Note Vaccination History Above</p> <div style="border: 2px solid red; padding: 5px;"> <p>Submitted for Surveillance and/or Regulatory Compliance** (Test Result(s) Report NOT ISSUED) Surveillance Program (If Applicable): _____</p> </div> <p>_____</p> <p>**Must also mark a test condition</p>	<p>↓ SPECIMEN SOURCE CODE</p> <p>RESTRICTED TEST Pre-approved submitters ONLY. Submit a separate specimen for HIV. http://health.maryland.gov/laboratories/</p> <p><input type="checkbox"/> HIV</p> <p>Country of Origin: _____</p> <p>Rapid Test: Reactive Negative</p> <p>Date: ____/____/____</p> <p>Specimen stored refrigerated (2° - 8°C) after collection: Yes No</p> <p>Specimen transported on Cold Packs: Yes No</p> <p>Serum/ plasma stored frozen (≤ -20°C) after collection: Yes No</p> <p>HCV RNA Centrifugation Time: ____:____ a.m. p.m.</p> <p>Specimen Receipt Temperature (For MDH Lab Use Only)</p> <p style="text-align: right;">°C</p> <p>SPECIMEN SOURCE CODES PLACE CODE IN BOX NEXT TO TEST</p> <p>B Blood Specimen (5 ml) CSF Cerebrospinal Fluid Sample P Plasma Specimen S Serum Specimen (1 ml per test) U Urine Specimen</p>
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CLINIC CODES

EH – Employee Health
FP – Family Planning
MTY/PN – Maternity/Prenatal
NOD – Nurse of Day
STD/STI – Sexually Transmitted Disease/Infections
TB- Tuberculosis
CD- Communicable Disease
COR – Correctional Facility
Do not mark a box if clinic type does not apply

COMPLETING FORM

Press firmly – two part form
Type or print legibly
Printed labels are recommended
Please place labels on all copies of the form
Print or type the name of the person authorized to order test(s)
(This may be added to the pre-printed label.)
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 requests.
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 Information:

Outfit Unit 443-681-3777 or Fax 443-681-3850
E-mail mdhlabs.outfits@maryland.gov

For specific test requirements refer to:
“Guide to Public Health Laboratory Services”
Available Online:
health.maryland.gov/laboratories/Pages/home.aspx

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 bio-bag.
Review the Test Request Form to verify completeness including that the desired test(s) has/have been marked.
Use a separate bio-bag for each form and each temperature requirement. Place the specimen container in the zip lock portion of the bio-bag and seal it closed. Place the folded Test Request Form in the outside pocket of the bio-bag.
If multiple specimen containers are required for various tests marked on 1 form, place each container in a separate bio-bag to protect it from leakage/breakage of the other containers. Then place them all into an outer bio-bag with the Test Request Form in the pocket.

Verify that all specimen containers have been labeled as described above.

URINE SPECIMENS – REFRIGERATE PACKAGING AND SHIPPING

Double bag urine containers. Include absorbent material in the inner bio-bag and express air before sealing. Place this in a second bio-bag with the folded Test Request Form in the pocket of the outer bio-bag. Transport at refrigerated temperature.