



OFFICE OF LABORATORY SERVICES

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OLS USE ONLY

DIAGNOSTIC IMMUNOLOGY LABORATORY SPECIMEN SUBMISSION FORM

USE ONE FORM PER SPECIMEN

PATIENT INFORMATION

PATIENT ID (Chart #, etc.) <i>(optional)</i>		
LAST NAME	FIRST NAME	MI
DATE OF BIRTH	SS# (last 4 digits only)	
COUNTY OF RESIDENCE	SEX <input type="checkbox"/> Female <input type="checkbox"/> Male	
STREET ADDRESS		
CITY	STATE	ZIP
PATIENT PHONE NO. (include area code)		
RACE <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Other <input type="checkbox"/> American Indian/Alaskan <input type="checkbox"/> Native Hawaiian or other Pacific Islander	ETHNICITY <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unknown	
PATIENT TYPE (for Hepatitis Testing only) <p style="text-align: right;"><input checked="" type="checkbox"/> Investigation</p>		

DATE OF COLLECTION:

Program Type (Select ONE Only):	
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Project # D14-40
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

TEST REQUESTED (Select ONE Only):	
<input checked="" type="checkbox"/> Hepatitis B Screen	
<input checked="" type="checkbox"/> Hepatitis C Antibody	
<input type="checkbox"/>	

SOURCE OF SPECIMEN:	
<input checked="" type="checkbox"/> Blood / Serum	
<input type="checkbox"/>	
<input type="checkbox"/>	

HEPATITIS INFORMATION - RISK FACTORS (R. F.)	
<input checked="" type="checkbox"/> Pain Clinic Patient	Mark any additional risk factors below:
<input type="checkbox"/> Body piercing (non-commercial)	<input type="checkbox"/> Multiple partners
<input type="checkbox"/> IV drug user	<input type="checkbox"/> Tattoo (non-commercial)
<input type="checkbox"/> Blood transfusions	<input type="checkbox"/> Illicit non-IV drug use
<input type="checkbox"/> Healthcare worker	<input type="checkbox"/> Needle stick/blood splash
<input type="checkbox"/> Hemodialysis	<input type="checkbox"/> Pregnant (due date _____)
<input type="checkbox"/> History of incarceration	<input type="checkbox"/> Sexual contact
<input type="checkbox"/> Household contact	<input type="checkbox"/> Symptoms / Diagnosis of STD

HIV INFORMATION (Select all that apply)	
RISK FACTORS	HETEROSEXUAL RELATIONS WITH
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

SUBMITTER INFORMATION

FACILITY NAME Hancock County Health Department		
MAILING ADDRESS PO Box 578		
CITY New Cumberland	STATE WV	ZIP 26047
COUNTY Hancock County		
ATTENTION TO:		
PHONE NO. (include area code) 1-304-564-3343		
FAX NO. (include area code) 1-304-564-3410		

OLS USE ONLY <input type="checkbox"/> UNSAT Reason/ID:	ACC: DE: CKD:
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