OFFICE OF LABORATORY SERVICES
Andrea M. Labik, Sc.D. / Director
167 11th Avenue
South Charleston, WV 25303
PH: (304) 558-3530
FX: (304) 558-2006 or 6210

OLS USE ONLY

DIAGNOSTIC IMMUNOLOGY LABORATORY SPECIMEN SUBMISSION FORM

PATIENT INFORMATION

PATIENT ID (Chart #, etc.) *(optional)*

LAST NAME	FIRST NAME	MI

DATE OF BIRTH	SS# (last 4 digits only)

COUNTY OF RESIDENCE	SEX ❑ Female ❑ Male

STREET ADDRESS

CITY	STATE	ZIP

PATIENT PHONE NO.(include area code)

RACE	ETHNICITY
❑ White ❑ Asian ❑ Black ❑ Other ❑ American Indian/Alaskan ❑ Native Hawaiian or other Pacific Islander	❑ Not Hispanic or Latino ❑ Hispanic or Latino ❑Unknown

PATIENT TYPE(for Hepatitis Testing only)

X **Investigation**

CLINIC #

SUBMITTER INFORMATION

FACILITY NAME
Marshall County Health Department

MAILING ADDRESS
PO Box 429

CITY	STATE	ZIP
Moundsville	**WV**	**26041**

COUNTY
Marshall County

ATTENTION TO:

PHONE NO. (include area code)
1-304-845-7840

FAX NO. (include area code)
1-304-843-9837

OLS USE ONLY	ACC:
❑ UNSAT	DE:
Reason/ID:	CKD:

USE ONE FORM PER SPECIMEN

DATE OF COLLECTION:

Program Type (Select ONE Only):	
❑	❑
❑	❑
❑	❑
❑	❑ **Project # D14-40**
❑	❑
❑	❑

TEST REQUESTED (Select ONE Only):	
X **Hepatitis B Screen**	
X **Hepatitis C Antibody**	

SOURCE OF SPECIMEN:	
X **Blood / Serum**	

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

HIV INFORMATION (Select all that apply)	
RISK FACTORS	HETEROSEXUAL RELATIONS WITH

Revised 07/2014