



**DIAGNOSTIC IMMUNOLOGY LABORATORY SPECIMEN SUBMISSION FORM**

USE ONE FORM PER SPECIMEN

**PATIENT INFORMATION**

PATIENT ID (Chart #, etc.) <span style="float: right;">MAX. 17 CHARACTERS</span>		
LAST NAME	FIRST NAME	MI
DATE OF BIRTH	SS# (last 4 only, optional)	
IS PATIENT A RESIDENT OF THE FACILITY LISTED UNDER SUBMITTER INFORMATION? <input type="checkbox"/> Yes <input type="checkbox"/> No		
COUNTY OF RESIDENCE <i>(based on current physical address)</i>	SEX (at birth) <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Not specified	
STREET ADDRESS		
CITY	STATE	ZIP
PATIENT PHONE NO. (optional)		
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"/> Unknown <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	

**SUBMITTER INFORMATION**

THE INFORMATION BELOW IS FOR THE MAILING OR FAXING OF TEST REPORTS. PLEASE MAKE SURE THE MAILING ADDRESS AND FAX NUMBER ARE ACCURATE.		
OLS SHOULD BE NOTIFIED OF ANY CHANGES TO THIS INFORMATION AS SOON AS POSSIBLE.		
FACILITY NAME		
MAILING ADDRESS (NO P.O. BOX)		
CITY	STATE	ZIP
COUNTY		
ATTENTION TO		
PHONE NO. (include area code)		
FAX NO. (include area code)		

**DATE OF COLLECTION:**

**PROGRAM / CLINIC TYPE: (select only ONE)**

<input type="checkbox"/> Family Planning	<input type="checkbox"/> STD / HIV Services
<input type="checkbox"/> Hospital	<input type="checkbox"/> Correctional Facility
<input type="checkbox"/> Project HRP	<input type="checkbox"/> Project # _____

**TEST REQUESTED: (select only ONE)**

<input type="checkbox"/> CT/NG Amplified NAAT	<input type="checkbox"/> Rubella Screen
<input type="checkbox"/> HIV Screen	<input type="checkbox"/> Syphilis Screen (RPR)
<input type="checkbox"/> HIV Confirmation	

**SOURCE OF SPECIMEN:**

<input type="checkbox"/> Blood / Serum	<input type="checkbox"/> Urine
<input type="checkbox"/> Throat	<input type="checkbox"/> Rectal

Is patient pregnant?  N/A  No  Yes (due date \_\_\_\_\_)

**REASON FOR TEST**

<input type="checkbox"/> Routine Screen	<input type="checkbox"/> Re-screen of previous positive <i>[minimum of three (3) months after treatment]</i>
<input type="checkbox"/> Any symptom of STD	<input type="checkbox"/> Suspect / possible contact to STD <i>[new partner, multiple partners, polygamous partner]</i>
<input type="checkbox"/> Known contact to STD	<input type="checkbox"/> IUD insertion

**RISK FACTOR INFORMATION (select ALL that apply)**

PATIENT RISK FACTORS	PARTNER RISK FACTORS
<input type="checkbox"/> Sex with female	<input type="checkbox"/> IV injection drug user
<input type="checkbox"/> Sex with male	<input type="checkbox"/> Bisexual male
<input type="checkbox"/> Injected non-Rx drugs	<input type="checkbox"/> Person with hemophilia/clotting disorder
<input type="checkbox"/> Rec'd Clotting Factor F VII A and/or F IX B	<input type="checkbox"/> Transfusion recipient WITH documented HIV positive and/or transplant WITH documented HIV positive
<input type="checkbox"/> Rec'd transplant or artificial insemination	<input type="checkbox"/> Person with AIDS or documented HIV positive
<input type="checkbox"/> Blood transfusion	<b>PLACE HIV TEST FORM BARCODE LABEL HERE</b>
<input type="checkbox"/> Healthcare worker and/or laboratory worker	
<input type="checkbox"/> Unspecified risk	

COMMENTS:

**OLS USE ONLY**

<input type="checkbox"/> UNSAT   Reason:	ACC:
<input type="checkbox"/> UNRELIABLE   Reason:	DE:
<input type="checkbox"/> SATISFACTORY	CKD: