OFFICE OF LABORATORY SERVICES
167 11th Avenue | South Charleston, WV 25303
PH: (304) 558-3530 | FX: (304) 558-2006

PLACE BARCODE HERE

OLS USE ONLY

DIAGNOSTIC IMMUNOLOGY LABORATORY SPECIMEN SUBMISSION FORM

USE ONE FORM PER SPECIMEN

PATIENT INFORMATION

PATIENT ID (Chart #, etc.) *MAX. 17 CHARACTERS*

LAST NAME	FIRST NAME	MI

DATE OF BIRTH	SS# *(last 4 only, optional)*

IS PATIENT A RESIDENT OF THE FACILITY LISTED UNDER SUBMITTER INFORMATION? ❑ Yes ❑ No

COUNTY OF RESIDENCE *(based on current physical address)*	SEX (at birth) ❑ Female ❑ Male ❑ Not specified

STREET ADDRESS

CITY	STATE	ZIP

PATIENT PHONE NO. *(optional)*

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

OLS USE ONLY	
❑ UNSAT | Reason:	ACC:
❑ UNRELIABLE | Reason:	DE:
❑ SATISFACTORY	CKD:

DATE OF COLLECTION:

PROGRAM / CLINIC TYPE: (select only ONE)	
❑ Family Planning	❑ STD / HIV Services
❑ Hospital	❑ Correctional Facility
❑ Project HRP	❑ Project # ___________________________

TEST REQUESTED: (select only ONE)	
❑ CT/NG Amplified NAAT	❑ Rubella Screen
❑ HIV Screen	❑ Syphilis Screen (RPR)
❑ HIV Confirmation	

SOURCE OF SPECIMEN:	
❑ Blood / Serum	❑ Urine
❑ Throat	❑ Rectal

Is patient pregnant? ❑ N/A ❑ No ❑ Yes (due date ___________________)

REASON FOR TEST	
❑ Routine Screen	❑ Re-screen of previous positive [*minimum of three (3) months after treatment*]
❑ Any symptom of STD	❑ Suspect / possible contact to STD [*new partner, multiple partners, polygamous partner*]
❑ Known contact to STD	❑ IUD insertion

RISK FACTOR INFORMATION (select ALL that apply)

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

COMMENTS:

FAILURE TO COMPLETE THIS FORM IN ITS ENTIRETY MAY RESULT IN DELAYED TEST RESULTS OR REJECTION OF SPECIMEN