

**TB CLINIC FORM
ONLY**

**DIAGNOSTIC IMMUNOLOGY LABORATORY SPECIMEN
SUBMISSION FORM**

**TB CLINIC FORM
ONLY**

USE ONE FORM PER SPECIMEN

PATIENT INFORMATION		
PATIENT ID (Chart #, MRN, etc.)		Max 17 Characters
LAST NAME	FIRST NAME	MI
DATE OF BIRTH	SS# (LAST 4 DIGITS ONLY)	
COUNTY OF RESIDENCE	SEX (at Birth) <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Not Specified	
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: <input type="checkbox"/> Employee <input type="checkbox"/> Patient <input type="checkbox"/> Investigation		

DATE OF COLLECTION:

PROGRAM/CLINIC TYPE (SELECT ONE ONLY)		
<input checked="" type="checkbox"/> TB CLINIC (NO CHARGE TESTING)		
TEST REQUESTED (SELECT ONE ONLY)		
<input checked="" type="checkbox"/> HEPATITIS B PANEL	<input checked="" type="checkbox"/> HEPATITIS C PANEL	<input checked="" type="checkbox"/> HIV PANEL
SOURCE OF SPECIMEN:		
<input checked="" type="checkbox"/> BLOOD / SERUM		

IS PATIENT PREGNANT? N/A NO YES: DUE DATE _____

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		
CITY	STATE	ZIP
COUNTY		
ATTENTION TO		
PHONE NO. (INCLUDE AREA CODE)		
FAX NO. (INCLUDE AREA CODE)		

HEPATITIS B INFORMATION: RISK FACTORS	
<input type="checkbox"/> Body piercing (non-commercial)	<input type="checkbox"/> Multiple Partners
<input type="checkbox"/> Tattoo (non-commercial)	<input type="checkbox"/> Healthcare Worker
<input type="checkbox"/> Needle stick / blood splash	<input type="checkbox"/> Current non-IV drug user
<input type="checkbox"/> Currently injecting drugs	<input type="checkbox"/> Blood transfusions
<input type="checkbox"/> History of Incarceration	<input type="checkbox"/> Hemodialysis
<input type="checkbox"/> Symptoms / Diagnosis of STD	<input type="checkbox"/> Sexual contact
<input type="checkbox"/> Household Contact	

HEPATITIS C INFORMATION: RISK FACTORS	
<input type="checkbox"/> Contact with POSITIVE+ Hepatitis C patient	
<input type="checkbox"/> Body piercing (non-commercial)	<input type="checkbox"/> Multiple Partners
<input type="checkbox"/> Tattoo (non-commercial)	<input type="checkbox"/> Healthcare Worker
<input type="checkbox"/> Needle stick / blood splash	<input type="checkbox"/> Current non-IV drug user
<input type="checkbox"/> Currently injecting drugs	<input type="checkbox"/> Blood transfusions
<input type="checkbox"/> History of Incarceration	<input type="checkbox"/> Hemodialysis
<input type="checkbox"/> Symptoms / Diagnosis of STD	<input type="checkbox"/> Sexual contact
<input type="checkbox"/> Household Contact	

RISK FACTOR INFORMATION (SELECT ALL THAT APPLY)	
PATIENT RISK FACTORS	PARTNER RISK FACTORS
<input type="checkbox"/> Sex with female	<input type="checkbox"/> Bisexual female
<input type="checkbox"/> Sex with male	<input type="checkbox"/> Bisexual male
<input type="checkbox"/> Injected non-RX drugs	<input type="checkbox"/> IV injection drug user
<input type="checkbox"/> Rec'd clotting Factor F VII A and/or F IX B	<input type="checkbox"/> Person with AIDS or documented HIV+
<input type="checkbox"/> Received transplant or artificial insemination	<input type="checkbox"/> Transfusion recipient WITH documented HIV+ and/or transplant WITH documented HIV+
<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> Person with hemophilia/clotting disorder
<input type="checkbox"/> Healthcare worker and/or laboratory worker	PLACE HIV TEST FORM BARCODE LABEL HERE
<input type="checkbox"/> Unspecified Risk(s)	

Provider and /or OLS notes:	
OLS USE ONLY <input type="checkbox"/> UNSAT REASON/ID:	ACC: DE: CKD: