BT AND EMERGING PATHOGENS

N.C. Department of Health and Human Services
State Laboratory of Public Health
4312 District Drive
Raleigh, NC 27607-8047 (Fed Ex only)

Please Give All Information Requested *Attach Printed Label Below*

Patient Information

Last Name				
First Name	MI			
Maiden Name/Surname				
Address/Attention:				
Street Address:			Address 2:	City:
State:	Zip Code:	County Code:	County Name:	Phone Number:
SSN: __ __ __/__ __/__ __ __ __			Medicaid Number (if applicable): __ __ __ __ __ __ __ __ __ __	
Medical Record Number:			Date of Birth: __ __/__ __/__ __ __ __	
Sex: ❑ Male ❑ Transgender M2F ❑ Female ❑ Transgender F2M ❑ Unknown ❑ Transgender Unknown ❑ Ambiguous			Race (mark all that apply): ❑ White ❑ American Indian/ Alaska Native ❑ Black ❑ Asian ❑ Native Hawaiian/ Pacific Isles ❑ Unknown	Ethnicity: ❑ Hispanic or Latino Origin ❑ Non-Hispanic ❑ Unknown

Submitter

EIN: ___ ___ ___ ___ ___ ___ ___ ___ ___ - ___ ___	Submitter Name:	
Address:	Address 2:	City:
State:	Zip Code:	County Name:
Phone Number:	Email Address:	
Ordering Provider NPI:	Ordering Provider First and Last Name:	
Contact Name:	Contact Phone #:	Contact Fax #:

Specimen

Collection Date: __ __/__ __/__ __ __ __	Reason for Testing (ICD-10 Dx Code): __ __ __ __ __ __ __
Specimen Type: ❑ Isolated Organism (describe):_____ _____ ❑ Smear ❑ Clinical	**Specimen Source:** ❑ Blood ❑ CSF ❑ Urine ❑ NP ❑ Stool ❑ Sputum ❑ Wound Site: _____ ❑ Other: _____
Examine For: _____	Laboratory Number: *Do Not Write in this Space*

Other

Clinical and/or Epidemiological Information:

Any Associated Illness: _____

Pertinent/Clinical/Lab Findings: _____

Foreign or Domestic Travel? Where? _____ When? _____