SPECIAL SEROLOGY

N.C. Department of Health and Human Services
State Laboratory of Public Health
4312 District Drive ● P.O. Box 28047
Raleigh, NC 27611-8047

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: __ __/__ __/__ __ __ __		If Female, Pregnant? ❑ Yes ❑ No ❑ Unknown
Sex: ❑ Male ❑ Female ❑ Unknown ❑ Ambiguous ❑ Transgender M2F ❑ Transgender F2M ❑ Transgender Unknown		Race (mark all that apply): ❑ White ❑ Black ❑ Asian ❑ Unknown ❑ American Indian/ Alaska Native ❑ Native Hawaiian/ Pacific Isles		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:	Fax Number:
Ordering Provider NPI:	Ordering Provider First and Last Name:	

Specimen (continued on page 2)

Specimen source(s):	Collection Date(s):	Collector's Initials:	Laboratory Number(s): *Do Not Write in this Space*
❑ Acute Serum *(within 7 days of onset)*	__ __/__ __/__ __ __ __		
❑ Convalescent Serum	__ __/__ __/__ __ __ __		
❑ Whole Blood	__ __/__ __/__ __ __ __		
❑ CSF	__ __/__ __/__ __ __ __		
❑ Urine	__ __/__ __/__ __ __ __		
❑ Amniotic Fluid	__ __/__ __/__ __ __ __		
Onset Date: __ __/__ __/__ __ __ __			Reason for Testing (ICD-10 Dx Code): __ __ __ __ __ __ __

Serologic Diagnostic Panels Available: *(Check one or more boxes, as needed)*

❑ Arboviral Panel (Eastern Equine Encephalitis, Western Equine Encephalitis, St. Louis Encephalitis, La Crosse Encephalitis, and West Nile)

❑ Rickettsia Panel (*Rickettsia rickettsii*, *Rickettsia typhi*, *Ehrlichia* species)

Specimen (continued from page 1)

Exanthems: ***(All suspect cases must be approved for testing by the Communicable Disease Branch (CDB) prior to submission of specimen to the State Lab. CDB can be reached at 919-733-3419.)***

❑ Measles, Rubella ❑ Varicella Zoster, IgG ❑ Mumps, IgG

Single Agent Diagnostic Tests: (Check one or more boxes, as needed)

❑ Dengue

❑ Chikungunya

❑ Zika ****The Physician Attestation (below) must be signed prior to testing.****

❑ Other: _____

❑ Prior approval/consultation received from: _____

❑ Please forward specimen to CDC for testing. (Attach a completed CDC 50.34 DASH form).

Other Patient Information

Patient Signs and Symptoms: *(Check all that apply)*

General	**Rash**	**Respiratory**	**CNS**	**Cardiovascular**
❑ Fever to ___°F	❑ Macular	❑ Cough	❑ Seizures	❑ Chest Pain
❑ Headache	❑ Papular	❑ Pneumonia	❑ Meningitis	❑ Pericarditis
❑ Fatigue	❑ Vesicular	❑ Bronchitis	❑ Encephalitis	❑ Myocarditis
❑ Sore Throat	❑ Petechial	❑ Croup	❑ Nuchal rigidity	❑ Pleurodynia
❑ Jaundice	❑ Focal	❑ Pharyngitis	❑ Paralysis	
❑ Conjunctivitis	❑ Hemorrhagic			
❑ Arthralgia/Myalgia				
❑ Nausea/Vomiting				

If pregnant, due date: __ __/__ __/__ __ __ __

Recent Vaccination History:

_____

_____

_____

Travel History:

Area(s): _____

_____

Dates: _____

Physician Attestation for Zika Testing

Zika virus assays are intended for use with specimens collected from individuals meeting CDC Zika virus clinical criteria (e.g., clinical signs and symptoms associated with Zika virus infection) and/or CDC Zika virus epidemiological criteria (e.g., history of residence in or travel to a geographic region with active Zika transmission at the time of travel, or other epidemiologic criteria for which Zika virus testing may be indicated as part of a public health investigation).

NCSLPH provides testing to patients when the following criteria are met:

- A pregnant woman who:
  - Has ongoing possible Zika virus exposure
  - Has had prenatal ultrasound findings consistent with congenital Zika infection
- An individual with symptoms associated with Zika virus infection (rash, joint pain, fever, and/or conjunctivitis) who:
  - Spent time in an area with risk for Zika virus transmission, or
  - Had unprotected sex with a partner who spent time in an area with risk for Zika virus transmission

❑ I certify that the patient I am requesting Zika testing for meets the criteria outlined above.*

Physician Name (Print) _____

Physician Signature _____

*** For further guidance regarding eligibility for Zika testing, please visit the Zika Virus Testing page on the NCSLPH website at http://slph.ncpublichealth.com/zika/default.asp**