

Patient Name (Last, First) :			Submitted By / Mailing Address:		
Patient County and Zip:			Phone Number:		
Medicaid #:					
Sex:	Race:	Date of Birth:	Onset Date:	Collection Date:	

SEROLOGY acute convalescent

<p>HIV <input type="checkbox"/> Confirmation of Positive HIV Rapid Test <input type="checkbox"/> HIV Antibody Screen</p> <p>Syphilis <input type="checkbox"/> Routine <input type="checkbox"/> Symptomatic <input type="checkbox"/> VDRL – serum or CSF <input type="checkbox"/> TPPA</p> <p>Hepatitis B <input type="checkbox"/> Surface Antibody (titer) <input type="checkbox"/> Core Antibody <input type="checkbox"/> Surface Antigen</p> <p><input type="checkbox"/> Hepatitis C</p>	<p>Rubella <input type="checkbox"/> IgG <input type="checkbox"/> IgM</p> <p>Rubeola (Measles) <input type="checkbox"/> IgG <input type="checkbox"/> IgM</p> <p>Mumps <input type="checkbox"/> IgG <input type="checkbox"/> IgM</p> <p>Varicella <input type="checkbox"/> IgG <input type="checkbox"/> IgM</p> <p><input type="checkbox"/> Herpes IgG Antibody, Types 1 & 2</p>	<p><input type="checkbox"/> West Nile Virus IgG/IgM (Onset Date Required)</p> <p><input type="checkbox"/> Hantavirus IgG/IgM</p> <p><input type="checkbox"/> Lyme Antibody -Referred to CDC (CDC Case Report Form Required - Contact IBL)</p> <p><input type="checkbox"/> Other _____ Prior Notification Required</p>
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VIRAL CULTURE Specimen type:

<p><input type="checkbox"/> Upper Respiratory Virus Panel Influenza A & B, Parainfluenza 1,2,3, Adenovirus, Respiratory Syncytial Virus</p> <p><input type="checkbox"/> Herpes Simplex Virus Culture Type 1 & 2</p>	<p><input type="checkbox"/> Enterovirus Culture Coxsackie, Enterovirus, Polio, Echovirus</p> <p><input type="checkbox"/> Mumps Virus Culture</p>
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Comments: