

<b>NYC</b> Health	<b>VIRAL SEROLOGY</b> <b>PUBLIC HEALTH LABORATORY TEST REQUEST</b>	FOR LAB USE ONLY
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DATE \* (MM/DD/YYYY)

**\*Required information**

**1. PATIENT INFORMATION**

PATIENT LAST NAME *:		PATIENT FIRST NAME *:	
<input style="width:90%;" type="text"/>		<input style="width:90%;" type="text"/>	
DATE OF BIRTH * (MM/DD/YYYY):	Sex *:	PATIENT ID#/MEDICAL RECORD#:	
<input style="width:100%;" type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	<input style="width:90%;" type="text"/>	
ADDRESS:	CITY:	STATE:	ZIP:
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>
TELEPHONE:                      Ext.	PHYSICIAN: (if other than submitter)	Pager/Cell:	
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	

**2. SUBMITTER INFORMATION**

NAME OF SUBMITTING HOSPITAL, LABORATORY, or OTHER FACILITY Etc. *:		PROVIDER ID#:	
<input style="width:90%;" type="text"/>		<input style="width:90%;" type="text"/>	
PRIMARY CONTACT or PHYSICIAN- LAST NAME *:		FIRST NAME *:	
<input style="width:90%;" type="text"/>		<input style="width:90%;" type="text"/>	
ADDRESS *:			
<input style="width:100%;" type="text"/>			
CITY *:		STATE *:	ZIP *:
<input style="width:100%;" type="text"/>		<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>
TELEPHONE *:	Ext.	Pager/Cell *:	Fax:
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>
		EMAIL:	
		<input style="width:100%;" type="text"/>	

**3. SPECIMEN INFORMATION**

DATE OF COLLECTION * (MM/DD/YYYY):	<input style="width:100%;" type="text"/>	TIME OF COLLECTION * [00:00]:	<input type="checkbox"/> <input type="checkbox"/> AM <input type="checkbox"/> <input type="checkbox"/> PM
(where applicable)			
Reason for submission *	<input type="checkbox"/> DIAGNOSTIC <input type="checkbox"/> CONFIRMATORY <input type="checkbox"/> OUTBREAK <input type="checkbox"/> DOHMH REQUEST (if checked complete A & B below)		
A. DOHMH bureau	<input type="checkbox"/> BCD <input type="checkbox"/> BOI <input type="checkbox"/> BTBC <input type="checkbox"/> BSTD <input type="checkbox"/> OTHER (specify): <input style="width:100%;" type="text"/>		DOHMH EVENT CODE: <input style="width:100%;" type="text"/>
B. DOHMH contact	Last Name: <input style="width:100%;" type="text"/>	First Name: <input style="width:100%;" type="text"/>	
Is this submission for referral? *	<input type="checkbox"/> NO <input type="checkbox"/> YES (IF YES CHECK ONE): <input type="checkbox"/> NYS <input type="checkbox"/> CDC <input type="checkbox"/> OTHER (specify) <input style="width:100%;" type="text"/>		
Specimen type *	<input type="checkbox"/> Blood <input type="checkbox"/> Serum <input type="checkbox"/> Plasma <input type="checkbox"/> Other (specify type): <input style="width:100%;" type="text"/>		
Additional testing information *	Current diagnosis: <input style="width:100%;" type="text"/>		
	Serum status: <input type="checkbox"/> Acute <input type="checkbox"/> Convalescent <input type="checkbox"/> Unknown		
	Exposure date (MM/DD/YYYY): <input style="width:100%;" type="text"/>		Date of symptom onset (MM/DD/YYYY): <input style="width:100%;" type="text"/>
	Perinatal Hepatitis B Prevention Unit Case#: <input style="width:100%;" type="text"/>		
Additional Comments <input style="width:100%;" type="text"/>			

**4. TEST(S) REQUESTED\***

<input type="checkbox"/> Hepatitis A Virus IgG (HAV IgG)	<input type="checkbox"/> Hepatitis C Virus Antibody (Anti-HCV)	<input type="checkbox"/> Rubella Virus IgG
<input type="checkbox"/> Hepatitis A Virus IgM (HAV IgM)	<input type="checkbox"/> Herpes Simplex Virus (HSV 1 & 2 IgG)	<input type="checkbox"/> Rubella Virus IgM
<input type="checkbox"/> Hepatitis B Core Virus IgG (HBcAb IgG)	<input type="checkbox"/> Measles Virus IgG	<input type="checkbox"/> Varicella-Zoster Virus IgG
<input type="checkbox"/> Hepatitis B Core Virus IgM (HBcAb IgM)	<input type="checkbox"/> Measles Virus IgM	<input type="checkbox"/> Varicella-Zoster Virus IgM
<input type="checkbox"/> Hepatitis B Surface Virus Antibody (HBsAb)	<input type="checkbox"/> Mumps Virus IgG	<input type="checkbox"/> Other (specify): <input style="width:100%;" type="text"/>
<input type="checkbox"/> Hepatitis B Surface Virus Antigen (HBsAg)	<input type="checkbox"/> Mumps Virus IgM	<input type="checkbox"/> Other (specify): <input style="width:100%;" type="text"/>

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\*Failure to provide the required information or any discrepancy relating to the specimen submitted, may result in an inability to test or a delay in the release of test results.