|  |
| --- |
| **CONFIDENTIAL REPORT: LABORATORY EVIDENCE OF CERTAIN COMMUNICABLE DISEASES****USE FOR REPORTING TO: MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE** |
| **USE FOR ALL COMMUNICABLE CONDITIONS EXCEPT HIV and CD4. (Use form DHMH 4492 for HIV and CD4.)** |
| **(PLEASE TYPE OR PRINT USING BLACK INK.)** |
| PATIENT LAST NAME FIRST MIDDLE INITIAL | HOSPITAL NUMBER | PREGNANT? (FEMALE)YES 🞎 NO 🞎 |
| DATE OF BIRTH | AGE | SEX | ETHNICITYHISPANIC 🞎 NON-HISPANIC 🞎 |  | RACE |
| NUMBER STREET APT CITY STATE ZIP COUNTY (AREA CODE) PHONE |
| ORDERING PROVIDER NAME |
| NUMBER STREET SUITE CITY STATE ZIP COUNTY (AREA CODE) PHONE (AREA CODE) FAX |
| ORDERING FACILITY NAME |
| NUMBER STREET SUITE CITY STATE ZIP COUNTY (AREA CODE) PHONE |
| DATE SPECIMEN COLLECTED | DATE SPECIMEN RECEIVED | DATE RESULTED | LAB ACCESSION NUMBER |
| TYPE OF SPECIMEN |
| Sputum 🞎 | Stool 🞎 | Pharyngeal Swab 🞎 | Discharge 🞎 |
| Blood 🞎 | CSF 🞎 | Washing 🞎 | Other (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| SITE OF SPECIMEN (CERVIX, EYE, ETC.) |
| NAME OF TEST | TEST NUMBER OR CODE |
| RESULT WITH REFERENCE RANGE & INTERPRETATION |
| (IF AN ORGANISM RESULT: INCLUDE SPECIES, SEROGROUPING, OR OTHER SUBTYPING IF KNOWN) |
| IF A HEPATITIS C RESULT: |
| Hep C Antibody (Rapid Test) | Hep C Antibody (ELISA) | Hep C RNA | Hep A IgM | Hep B Core IgM |
| LAB NAME (LAB PERFORMING THE TEST) | LAB CLIA NUMBER |
| LAB ADDRESS |
| LAB DIRECTOR | LAB (AREA CODE) PHONE | DATE OF REPORT |

DHMH 1281 **SEND TO YOUR LOCAL HEALTH DEPARTMENT**

Revised MAY 31, 2017 For more forms or information, go to <http://phpa.health.maryland.gov/Pages/what-to-report.aspx>