

Must complete the test request authorization information (This is where reports will be sent). Include the name of Healthcare provider who can legally order the test(s) in "Test Request Authorized by"

Request Arbovirus Travel-Associated Panel. Provide specimen source:

Indicate "S" for serum – (SST or aliquot) or whole clotted blood (red top)

Accompanying specimens*:

Indicate "B" for whole unclotted blood with EDTA (Purple top) **UNSPUN**

Indicate "U" for urine. (Leak-proof sterile urine cup)


Indicate "CSF" for Cerebrospinal fluid (Leak-proof sterile tube or vial)

*Urine, Whole blood, and CSF MUST be submitted with an accompanying serum specimen.

Complete patient's Travel history (location and dates), symptoms (or asymptomatic), pregnancy status (including weeks of gestation) vaccination history, & immune status

For questions on Zika Virus testing, please contact the lab:
PCR: (443) 681-3923/3924
Serology: (443) 681-3932/3937

Laboratories Administration MDH
1770 Ashland Ave • Baltimore, MD 21205
443-681-3800 <http://health.maryland.gov/laboratories/>
Robert A. Myers, Ph.D., Director

 **MARYLAND**
Department of Health

SEROLOGICAL TESTING

STATE LAB Use Only

TYPE OR PRINT REQUIRED INFORMATION OR PLACE LABELS ON BOTH COPIES

Health Care Provider: _____
Address: _____
City: _____ County: _____
State: _____ Zip Code: _____
Contact Name: _____
Phone #: _____ Fax #: _____
Test Request Authorized by: _____

Patient SS # (last 4 digits): _____
Last name: _____ M.I. _____
First Name: _____
Date of Birth (mm/dd/yyyy): ____/____/____
Address: _____
City: _____ County: _____
State: _____ Zip Code: _____

Sex: Male Female Transgender M to F Transgender F to M
Ethnicity: Hispanic or Latino Origin? Yes No
Race: American Indian/Alaska Native Asian Black/African American Native Hawaiian/Other Pacific Islander White
MRN/Case #: _____
Date Collected: ____/____/____
Previous Test Done? No Yes
Onset Date: ____/____/____ Exposure Date: ____/____/____

Arbovirus Panels (Serum or CSF)
Mandatory: Onset Date, Collection Date and Travel History
Arbovirus Endemic Panel (WNV, EEE, SLE, LAC)
Arbovirus Travel-Associated Panel (Chikungunya, Dengue, Zika)
Based on information provided PCR and Immunological assays will be performed.
Required information, check all that apply:
DIAGNOSIS: Aseptic Meningitis Encephalitis Other
SYMPTOMS: Headache Fever Stiff Neck Altered Mental State Muscle Weakness Rash Other:
ILLNESS FATAL? Yes No
TRAVEL HISTORY (Dates and Places)
IMMUNIZATIONS: Yellow fever? Yes No
Flavivirus? Yes No
IMMUNOCOMPROMISED? Yes No

Hepatitis B Screen (HBs antigen only)
Prenatal patient? Yes No
*Hepatitis B Panel: (HBsAg, HBsAb)
*Hepatitis B post vaccine (HBsAb)
Hepatitis C screen (HCV Ab only)
Herpes Simplex Virus (HSV) types 1&2
Legionella
Leptospira
Lyme Disease
*MMRV Immunity Screen: (Measles (Rubeola) Mumps, Rubella, Varicella, (Chickenpox) IgG Ab only)
Mononucleosis – Infectious
*Mumps Immunity Screen
Mycoplasma
Rocky Mountain Spotted Fever (RMSF)
*Rabies (RFFIT) (*List vaccination dates above)
*Rubella Immunity Screen
*Rubeola (Measles) Immunity Screen
Schistosoma
Strongyloides
Syphilis – Previously treated? Yes No
Toxoplasma
Varicella Immunity Screen
VDRL (CSF only)
CDC/Other Test(s)
Add'l Specimen Codes

RESTRICTED TEST
Pre-approved submitters Only
Submit a separate specimen for HIV
<http://health.maryland.gov/laboratories/>
Country of Origin: _____
Rapid Test: Positive Negative
Date: ____/____/____
Specimen stored refrigerated (2 - 8 °C) after collection: Yes No
Specimen transported on Cold Packs: Yes No

ASPERGILLUS
BABESIA MICROTI
CHAGAS DISEASE
CHLAMYDIA (group antigen IgG)
COXIELLA BURNETII (Q Fever)
CRYPTOCOCCA (antigen)
CYTOMEGALOVIRUS (CMV)
EHRlichia
EPSTEIN-BARR VIRUS (EBV)
HEPATITIS A SCREEN (IgM Ab only, acute infection)
Call Lab (443-681-3889) prior to submitting

Prior arrangements have been made with the following MDH Lab Administration employee:
Zika Virus
Approved by: ####
*Please Note Vaccination History Above

Client

Specimen Source Code: _____
PLACE CODE IN BOX NEXT TO TEST
B Blood (5 ml)
CSF Cerebrospinal Fluid
Lavender Top Tube
P Plasma
S Serum (1 ml per test)
U Urine

Patient's first & last names must be on the specimen container and exactly match the lab slip

Collection Date and Onset of Symptoms Date **MUST** be completed

If specimens other than whole blood, urine, serum, or CSF are being requested, please note type of specimen here, e.g.:
Fresh or Fixed Tissue
Amniotic Fluid

You must write "**Zika Virus**" to request testing
Include the name of the Local Health Department or DHMH Epidemiologist who approved testing

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SEROLOGICAL TESTING

TYPE OR PRINT REQUIRED INFORMATION OR PLACE LABELS ON BOTH COPIES	<input type="checkbox"/> EH <input type="checkbox"/> FP <input type="checkbox"/> MTY/PN <input type="checkbox"/> NOD <input type="checkbox"/> STD <input type="checkbox"/> TB <input type="checkbox"/> CD <input type="checkbox"/> COR		Patient SS # (last 4 digits):		
	Health Care Provider		Last name <input type="checkbox"/> SR <input type="checkbox"/> JR <input type="checkbox"/> Other:		
	Address		First Name M.I.		
	City	County	Date of Birth (mm/dd/yyyy) / /		
	State		Address		
	Contact Name:		City County		
	Phone #	Fax #	State Zip Code		
	Test Request Authorized by:				
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender M to F <input type="checkbox"/> Transgender F to M		Ethnicity: Hispanic or Latino Origin? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White				
MRN/Case #	DOC #	Outbreak #	Submitter Lab #		
Date Collected:	Time Collected: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	*Vaccination History _____			
Previous Test Done? <input type="checkbox"/> No <input type="checkbox"/> Yes	Name of Test _____ Date ____/____/____	<input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd	State Lab Number: _____		
	Name of Test _____ Date ____/____/____	<input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd	State Lab Number: _____		
Onset Date: ____/____/____ Exposure Date: ____/____/____		<input type="checkbox"/> Clinical Illness/Symptoms: _____			
↓ SPECIMEN SOURCE CODE		↓ SPECIMEN SOURCE CODE		↓ SPECIMEN SOURCE CODE	
Arbovirus Panels (Serum or CSF) Mandatory: Onset Date, Collection Date and Travel History		Hepatitis B Screen (HBs antigen only) Prenatal patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		▶▶ LAVENDER TOP TUBE REQUIRED ◀◀	
<input type="checkbox"/> Arbovirus Endemic Panel (WNV, EEE, SLE, LAC)		*Hepatitis B Panel: (HBsAg, HBsAb)		<input type="checkbox"/> Hemoglobin Disorders	
<input type="checkbox"/> Arbovirus Travel-Associated Panel (Chikungunya, Dengue, Zika) Based on information provided PCR and Immunological assays will be performed.		*Hepatitis B post vaccine (HBsAb)		Blood transfusion? (Last 4 months) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Required information, check all that apply: DIAGNOSIS: <input type="checkbox"/> Aseptic Meningitis <input type="checkbox"/> Encephalitis <input type="checkbox"/> Other		Hepatitis C screen (HCV Ab only)		Prenatal Screen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
SYMPTOMS: <input type="checkbox"/> Headache <input type="checkbox"/> Fever <input type="checkbox"/> Stiff Neck <input type="checkbox"/> Altered Mental State <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Rash <input type="checkbox"/> Other:		Herpes Simplex Virus (HSV) types 1&2		Father of Baby Screen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
ILLNESS FATAL? <input type="checkbox"/> Yes <input type="checkbox"/> No		Legionella		Guardian's Name if patient is a minor: _____	
TRAVEL HISTORY (Dates and Places) _____		Leptospira		Name of Mother of "at risk" baby: _____	
IMMUNIZATIONS: Yellow fever? <input type="checkbox"/> Yes <input type="checkbox"/> No Flavivirus? <input type="checkbox"/> Yes <input type="checkbox"/> No		Lyme Disease		RESTRICTED TEST Pre-approved submitters Only Submit a separate specimen for HIV http://health.maryland.gov/laboratories/	
IMMUNOCOMPROMISED? <input type="checkbox"/> Yes <input type="checkbox"/> No		*MMRV Immunity Screen: [Measles (Rubeola) Mumps, Rubella, Varicella, (Chickenpox) IgG Ab only]			
<input type="checkbox"/> Aspergillus		Mononucleosis – Infectious		HIV	
<input type="checkbox"/> Babesia microti		*Mumps Immunity Screen		Country of Origin: _____	
<input type="checkbox"/> Chagas disease		Mycoplasma		Rapid Test: <input type="checkbox"/> Reactive <input type="checkbox"/> Negative	
<input type="checkbox"/> Chlamydia (group antigen IgG)		Rocky Mountain Spotted Fever (RMSF)		Date: ____/____/____	
<input type="checkbox"/> Coxiella burnetii (Q Fever)		*Rabies (RFFIT) (*List vaccination dates above)		Specimen stored refrigerated (2 - 8 °C) after collection: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Cryptococca (antigen)		*Rubella Immunity Screen		Specimen transported on Cold Packs: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Cytomegalovirus (CMV)		*Rubeola (Measles) Immunity Screen		SPECIMEN SOURCE CODE: PLACE CODE IN BOX NEXT TO TEST	
<input type="checkbox"/> Ehrlichia		Schistosoma			
<input type="checkbox"/> Epstein-Barr Virus (EBV)		Strongyloides		B Blood (5 ml)	
<input type="checkbox"/> Hepatitis A Screen (IgM Ab only, acute infection)		Syphilis – Previously treated? <input type="checkbox"/> Yes <input type="checkbox"/> No		CSF Cerebrospinal Fluid	
Call Lab (443-681-3889) prior to submitting		Toxoplasma		L Lavender Top Tube	
		Varicella Immunity Screen		P Plasma	
		VDRL (CSF only)		S Serum (1 ml per test)	
		CDC/Other Test(s) Add'l Specimen Codes _____		U Urine	
		Prior arrangements have been made with the following MDH Lab Administration employee: _____			
		*Please Note Vaccination History Above			

CLINIC CODES

EH – Employee Health
FP – Family Planning
MTY/PN – Maternity/Prenatal
NOD – Nurse of Day
STD/STI – Sexually Transmitted Disease/Infections
CD- Communicable Disease
COR – Correctional Facility
Do not mark a box if clinic type does not apply

COMPLETING FORM

Type or print legibly
Print labels are recommended
Please print labels on all copies of form
Write the person's name that is authorized to order test in the box provided
Press firmly – two part form
Collection date and time are required by Law.
WRITE SPECIMEN CODE in box next to test
***Specimen/samples cannot be processed without a requested test.**

VACCINATION HISTORY

List vaccination dates for all Rabies, Hepatitis B and MMRv (Mumps, Measles, Rubella and Varicella) test request.
Rabies Vaccination history is required for all RFFIT test requests.

HIV TESTING

Include previous HIV Test information in the top section under Previous Test done.
Submit a separate specimen for HIV testing when multiple tests are ordered on the one form.

Questions/comments on the use of the specimen bags/storage/shipping or completing the form contact:

Accessioning Unit 443-681-3842 or 443-681-3793

To order collection kits and/or specimen collection supplies, contact:

Outfit Unit 443-681-3777 or Fax 443-681-3850

For Specific Test Requirements Refer to:

“Guide to Public Health Laboratory Services”

Available online: mdh.maryland.gov/laboratories

LABELING SPECIMENS/SAMPLES

Printed labels with all required patient information are recommended.

Print patient name, date of birth.

Print date and time the specimen was collected.

DO NOT cover expiration date of collection container.

Write specimen source on the collection container(s).

PACKAGING SPECIMENS FOR TRANSPORT

Never place specimens with different temperature requirements in the same biobag.

Use one (1) biobag per temperature requirement.

Review test request form to ensure all test(s) have been marked.

Verify all specimens have been labeled.

Place folded request form(s) in outer pouch of biobag.

Multiple specimens from the same patient with the same temperature requirements must be packaged together in one (1) biobag.

URINE SPECIMENS – Refrigerate PACKAGING AND SHIPPING

Double bag all urine specimens.

Urine specimens require absorbent towel in biobag with specimen (express excess air before sealing).

Place bagged urine specimen in second biobag with all refrigerated specimens from the same patient.

Place folded test request form(s) in outer pouch of second bag.