DHEC 1332 Submission Form

DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
Public Health Laboratory-8231 Parklane Road Columbia, SC 29223
(803) 896-0800

CLIA # 42D0658606

ALIGN BARCODE LABEL TO TOP OF BOX

Patient's Name (Last)	(First)	(MI)	Sex	Ethnicity	Race	Date of Birth

Address	City	State	Zip Code	County of Residence

Phone Number	Country of Birth	MCI Number	Local ID	Clinic ID

Sender No.	Sender Name	Billing Number	Program Number	Clinic Type

Reason for Visit

- ☐ Contact
- ☐ Contact-Chlamydia
- ☐ Contact-Gonorrhea
- ☐ Contact-Hepatitis A
- ☐ Contact-Hepatitis B
- ☐ Contact-Hepatitis C
- ☐ Contact-HIV/HD/MD notified
- ☐ Contact-HIV Positive
- ☐ Contact-HIV/PT notified
- ☐ Contact-Syphilis
- ☐ Diagnosis
- ☐ Family Planning - Annual
- ☐ Family Planning – Initial
- ☐ Fast Track Ineligible
- ☐ Fast Track Services
- ☐ Follow-Up
- ☐ Pregnancy Test
- ☐ PrEP Testing Services
- ☐ Premarital (State_____)
- ☐ Prenatal Visit
- ☐ Previous HIV Negative
- ☐ Previous HIV Positive
- ☐ Rapid Test Negative
- ☐ Rapid Test Positive
- ☐ Referral Agency
- ☐ Referred by outreach
- ☐ Referred by Drug Treatment Center
- ☐ Referred-Other
- ☐ Referred – Self
- ☐ Repeat Test/First Test_____
- ☐ Routine Screen
- ☐ Self-Report (Date: _____)
- ☐ Special Project
- ☐ Survey
- ☐ Test of Cure
- ☐ Unknown
- ☐ Volunteer/Medical
- ☐ Workplace Exposure
- ☐ Other_____

Serology Test Symptoms

Date of onset:
Fever:
Duration:
Rash (Type):

- ☐ Conjunctivitis
- ☐ Constipation
- ☐ Cough
- ☐ Diarrhea
- ☐ Headache
- ☐ Muscle Weakness
- ☐ Myocarditis
- ☐ Nuchal rigidity
- ☐ Paralysis
- ☐ Pericarditis
- ☐ Pharyngitis
- ☐ Pneumonia
- ☐ Rhinitis
- ☐ Vomiting

Specimen Information

Collection Date	Collection time	Ordering Physician, Provider and/or Nurse:
	☐ AM ☐ PM	

Specimen Type

Blood
- ☐ Clotted
- ☐ ETDA-Lavender/Purple
- ☐ Finger, Heel
- ☐ Plasma
- ☐ Serum
- ☐ Venipuncture*

Other
- ☐ CSF
- ☐ Urine

* for Blood Lead Only

Swab
- ☐ Cervical
- ☐ Rectal
- ☐ Throat
- ☐ Unknown
- ☐ Urethral
- ☐ Vaginal
- ☐ Other _____

Risk History (Past 12 months)

Client

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9
☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 31 ☐ 32 ☐ 33

Partner

☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20 ☐ 21 ☐ 22 ☐ 23
☐ 24 ☐ 25 ☐ 26 ☐ 27 ☐ 28 ☐ 29 ☐ 30

Chlamydia Test

Pregnancy Status	Symptoms	Risk
☐Yes ☐No ☐Unknown	☐Yes ☐No ☐Unknown	☐ Multiple partner ☐ New partner

Special Instructions and/or Comments:

Test Request

Virology

- ☐ Mumps IgG
- ☐ Mumps IgM
- ☐ Rubella IgG
- ☐ Rubella IgM
- ☐ Rubeola IgG
- ☐ Rubeola IgM
- ☐ Chikungunya IgM
- ☐ Dengue IgM
- ☐ Varicella IgG
- ☐ West Nile IgM
- ☐ Zika IgM

Analytical Chemistry

- ☐ Hg, Pb, Cd screen
- ☐ Lead (Blood)
- ☐ Trace Heavy Metals (includes As, Be, Cd, Ba, TI, Pb, and U)*Individual metals upon request
- ☐ Biomonitoring-No Demographics

Diagnostic Serology

GC/CT Detection	☐ GC and CT rRNA
Trichomonas Detection	☐ Trichomonas rRNA

Specimen type (Trichomonas):
☐ Urine ☐ Cervical ☐ Vaginal

Diagnostic Serology

- ☐ Hepatitis A IgG
- ☐ Hepatitis B ImmuneStatus/post-immune
- ☐ HIV
- ☐ Hepatitis A IgM
- ☐ Hepatitis B Surface Antibody
- ☐ HIV Viral Load
- ☐ Hepatitis B Anti-Core
- ☐ Hepatitis B Surface Antigen
- ☐ HIV/Syphilis
- ☐ Hepatitis B Core Antibody IgM
- ☐ Hepatitis B Diagnostic Profile
- ☐ Hepatitis C Antibody
- ☐ Hepatitis C Viral Load
- ☐ PrEP Panel F/U (HIV, Syphilis, CT/GC)
- ☐ PrEP Panel Initial (HIV, Syphilis, CT/GC, Hep C+B)
- ☐ Syphilis

1332

INSTRUCTIONS FOR COMPLETING REQUEST FORM

(May use printed patient lab label)

1. Enter patient name.
2. Write M = Male; F = Female or TX = Transgender M2F (Male to Female); or TY = Transgender F2M (Female to Male) in Sex box.
3. Enter ethnicity as follows: H = Hispanic/Latino, N = Non-Hispanic/Latino and U = Unknown
4. Enter race as follows: A = Asian; B = Black/African American; W= White; I = American Indian/Alaskan Native; P = Native Hawaiian/Other Pacific Islander; O= Other; U = Unknown/Unclassified
5. Enter date of birth (month, day and year. Example: Enter 03/06/1960 for the birthday March 6, 1960.)
6. Enter the patient address and five-digit zip code.
7. Enter county of residence and the 10-digit telephone number.
8. Enter Country of Birth.
9. Fill in patient MCI ID number (DHEC Clients only).
10. Enter local and clinic ID if applicable. (Private clients must provide a clinic ID)
11. Enter Sender number and Sender name.
12. Enter billing number if billing number is different from sender number
13. Enter Program number.
14. Enter Clinic Type.
15. In the Reason for Visit/Test box, check all that apply. Enter Date of Onset if applicable and check all symptoms that apply.
16. Enter the date and time of collection.
17. Enter Ordering Physician, Provider and/or Nurse if applicable. **Note: Please print.**
18. Check type/source of specimen.
19. Use the codes below to identify client and partner Risk Factors during the **PAST 12 MONTHS**. (Circle all that apply)

CLIENT RISK	**1**. Sex w/Female (F) **2**. Sex w/Male (M) **3**. Sex w/Transgender (T) **4**. Injection Drug Use (IDU) **5**. Used non-injectable drug or alcohol anytime during past 12-months **Received drugs/money in exchange for sex with a:** **6**. F/partner **7**. M/partner **8**. T/partner **Had sex while high on drugs with a:** **9**. F/partner **10**. M/partner **11**. T/partner **12**. Child of HIV infected mother **13**. Refused **14**. Other **31.** Without Condom **32.** Oral Sex w/Female **33.** Oral sex w/Male
PARTNER RISK	**Client had sex with:** **15**. F/IDU **16**. F/HIV + **17**. F/of unknown status **18**. F/who exchanges sex for drugs/money **19**. F/who has transfusions/transplant recipient **20**. M/IDU **21**. M/HIV + **22**. M/who exchanges sex for drugs/money **23**. Person who is a known MSM **(for female clients only)** **24**. M/of unknown status **25**. M/who has transfusions/transplant recipient **26**. T/IDU **27**. T/HIV + **28**. T/of unknown status **29**. T/who exchanges sex for drugs/money **30**. T/who has transfusions/transplant recipient

20. Chlamydia test: Check pregnancy status, risk, and symptom.
21. Enter Special Instructions and/or Comments.
22. Check test(s) requested.
23. Send one copy of the form with the specimen(s) to the lab. **Please Retain an Additional Copy For Your Records.**

Request forms will be retained following DHEC records retention schedule 8581, "Requests for Laboratory Analysis", Records Group Number: 169.