SC DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
PUBLIC HEALTH LABORATORY
8231 Parklane Road Columbia, SC 29223
(803) 896-0800
CLIA # 42D0658606

Date Received
PHL Specimen Number

Patient's Name (Last)	(Suffix)	(First)	(MI)	Sex	Ethnicity	Race	Date of Birth MO DAY YR

Address	City	State	Zip Code	County of Residence	Miscellaneous

MCI Number (CHD CLIENTS ONLY)	Local ID	Clinic ID	Program Number	Country of Birth	Phone Number

Sender Number	Billing Number	Travel History

Sender Address

REASON FOR VISIT/TEST *(Check all that apply)*

__01 Volunteer/Medical
__02 Prev. Health - New
__03 Prev. Health - Established
__04 Contact
__06 Other_____
__08 Follow-Up
__09 Prev. Health - Brief
__10 Special Project
__11 Contact-HIV Positive
__12 Contact-Syphilis
__13 Referred -Self
__14 Referred-Other _____
__15 Workplace Exposure
__16 Diagnosis
__17 Repeat Test/First Test ____
__18 Routine Screen
__19 Test of Cure
__24 Rapid HIV Test Positive
__26 Contact-Hepatitis A
__27 Contact-Hepatitis B
__28 Contact-Hepatitis C
__33 Premarital (State_____)
__34 Contact-HIV / PT notified
__35 Contact-HIV/ HD/MD notified
__37 Rapid HCV Positive
__38 Rapid HCV Negative
__39 Referred by Drug Trtmnt Ctr
__40 Previous HIV Positive
__42 Self-Report (Date_____)
__43 Pregnancy Test
__44 Contact-Gonorrhea
__45 Contact-Chlamydia
__46 Fast Track Services
__47 Fast Track Ineligible

SPECIMEN INFORMATION

Collection Date: MO / DAY / YR
Collection Time: __ AM __ PM
Initial: ( )

Specimen Type/Source

___ Blood
__Acute __Convalescent
__ 07 Finger; Heel; Toe Stick
__ 61 Plasma
__ 02 Serum/Serum-Separator
__ 01 Whole
_41 Venipuncture*
_51 EDTA-Lavender/Purple
_62 Clotted
___ 03 CSF
*Blood Lead Samples ONLY

___ Swab
_53 Cervical
_16 Urethral
_57 Vaginal
___ 17 Rectal
___ 13 Throat
___ 98 Unknown
___ 04 Urine
___ 99 Other

CHLAMYDIA TEST

Pregnancy Status: ___Yes ___No ___Unknown
Symptoms: ___Yes ___No ___Unknown
Risk: ___New Partner ___Multiple Partner

RISK HISTORY (Circle all that apply)

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

SEROLOGY TEST SYMPTOMS

Outbreak Number:_____ Date of onset:_____

Fever (temp)	Duration	Rash (type)

Please circle all that apply

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

ORDERING PHYSICIAN, PROVIDER AND/OR NURSE:

SPECIAL INSTRUCTIONS and/or COMMENTS:

TEST REQUESTED

SERUM CHEMISTRY

Patient: ___Fasting ___Non-Fasting

___713 ALT/AST
___715 TB Panel

HEMATOLOGY

Ship at room temperature

___760 CBC Panel
___780 CD4 (T4 Count)
___Initial Test
___ Repeat Test

TOXIC CHEMICALS

*Individual metals upon request
___882 Hg, Pb, Cd screen in blood
___852 Lead (Blood)
___885 Trace Heavy Metal Urine Screen (Includes As, Be, Cd, Ba,Tl, Pb, U)*

VIROLOGY

___118 Chikungunya IgM
___119 Dengue IgM
___135 Mumps IgG
___136 Mumps IgM
___005 Rubella IgG
___006 Rubella IgM
___132 Rubeola (Measles) IgG
___111 Rubeola Measles) IgM
___110 Varicella IgG
___117 West Nile IgM
___120 Zika IgM

GC/CT DETECTION

___504 Trichomonas vaginalis -rRNA
___505 GC –rRNA
___506 Chlamydia -rRNA
___507 GC and Chlamydia –rRNA
___514GC/Chlamydia/Trich. vaginalis- rRNA

PHL USE ONLY

SEROLOGY

___019 Hepatitis A, IgG
___020 Hepatitis A, IgM
___226 Hepatitis B Anti-Core
___220 Hepatitis B Core IgM Antibody
___223 Hepatitis B Diagnostic Profile
___222 Hepatitis B Immune Status/Post Imm.
___228 Hepatitis B Surface Antibody
___225 Hepatitis B Surface Antigen
___224 Hepatitis C Antibody (HCV)
___227 Hepatitis C RNA
___230 HIV-1/HIV-2
___235 HIV-1/HIV-2 & RPR
___234 HIV-1/2 & Geenius
___231 HIV-1 Quant. RNA
___001 Syphilis RPR
___004 Syphilis-if RPR Pos do TP-PA
___002 TP-PA
___ _____
___ _____

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. Fill in patient MCI ID number (DHEC Clients only).
9. Enter local and clinic ID if applicable. (Private clients must provide a clinic ID)
10. Enter Program number.
11. Enter Country of Birth.
12. Enter billing number if billing number is different from sender number
13. Enter Country of Birth.
14. Enter Travel History.
15. Enter the date and time of collection and initial**.**
16. Check type/source of specimen.
17. Enter Ordering Physician, Provider and/or Nurse if applicable. **Note: Please print.**
18. In the Reason for Visit/Test box, check all that apply.
19. Chlamydia test: Check pregnancy status, risk, and symptom.
20. 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

21. Enter the Outbreak Number.
22. Enter Date of Onset if applicable and circle all symptoms that apply.
23. Mark test requested.
24. Send top 2 copies of the form with the specimen(s) to the lab. **Please Retain Third Copy For Your Records.**

TB PANEL

Alkaline Phosphatase
ALT
AST
BUN
Creatinine
Glucose
T Bilirubin
Uric Acid
BUN/Creatinine Ratio* (Calculated values)