ORDERING PHYSICIAN, PROVIDER AND/OR NURSE:

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DHEC 1332 (Revised 4/2018)
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 Program number.
10. Enter Country of Birth.
11. Enter billing number if billing number is different from sender number
12. Enter Travel History.
14. Enter the date and time of collection and initial.
15. Check type/source of specimen.
16. Enter Ordering Physician, Provider and/or Nurse if applicable. Note: Please print.
17. In the Reason for Visit/Test box, check all that apply.
18. Enter the Outbreak Number.
19. Enter Date of Onset if applicable and circle all symptoms that apply.
20. Mark test requested.
21. Send top 2 copies of the form with the specimen(s) to the lab. Please Retain Third Copy For Your Records.

| 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 |
| 32. Oral Sex w/Female 33. Oral sex w/Male |


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)

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