



GEORGIA DEPARTMENT OF PUBLIC HEALTH  
PUBLIC HEALTH LABORATORY

**IMMUNOLOGY SUBMISSION FORM**

SUBMITTER INFORMATION	PATIENT INFORMATION
SUBMITTER CODE: <div style="display: flex; justify-content: space-around; width: 100%;"> <div style="border: 1px solid black; width: 25px; height: 25px; margin: 2px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px; margin: 2px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px; margin: 2px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px; margin: 2px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px; margin: 2px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px; margin: 2px;"></div> </div>	PATIENT ID: _____
CLINIC NAME: _____	NAME: _____ <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>Last</span> <span>First</span> <span>Middle</span> </div>
STREET: _____	RESIDENCE: _____ <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>Street</span> <span>City</span> <span>State</span> <span>Zip</span> </div>
CITY: _____	PHONE: _____ <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>County</span> <span>Home</span> <span>Work</span> <span>Cell/other</span> </div>
STATE _____ ZIP CODE: _____	DOB: ____/____/____ Medicaid # _____
PHONE NO: _____	RACE: <input type="checkbox"/> American Indian/Alaska Native
FAX NO: _____	<input type="checkbox"/> Asian
CONTACT NAME: _____	<input type="checkbox"/> Black/African-American
	<input type="checkbox"/> Native Hawaiian/Pacific Islander
	<input type="checkbox"/> Other
	<input type="checkbox"/> Unknown
	<input type="checkbox"/> White
	ETHNICITY: <input type="checkbox"/> Hispanic or Latino
	<input type="checkbox"/> Non-Hispanic or Latino
	<input type="checkbox"/> Unknown
	GENDER: <input type="checkbox"/> Male
	<input type="checkbox"/> Female
	<input type="checkbox"/> Unknown

SPECIMEN INFORMATION		
<b>Date of Collection:</b> ____/____/____	<b>Reason for Testing:</b> <input type="checkbox"/> Contact to STD <input type="checkbox"/> Court Ordered <input type="checkbox"/> Diagnosis <input type="checkbox"/> Repeat testing <input type="checkbox"/> Other: _____	<b>Clinical Information:</b> Date of Onset: _____ Previous Lab Results, if any: _____
<b>Source/Type:</b> <input type="checkbox"/> Blood <input type="checkbox"/> CSF <input type="checkbox"/> Plasma <input type="checkbox"/> Serum <input type="checkbox"/> Serum/Acute <input type="checkbox"/> Serum/Convalescent <input type="checkbox"/> Other: _____	<b>Shipped:</b> <input type="checkbox"/> Refrigerated <input type="checkbox"/> Room Temperature  <b>Please complete:</b> Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  Prenatal (Hepatitis B) EDC date _____	<b>Travel outside US:</b> Yes No If Yes, where? : _____  <b>Symptoms: (check all that apply)</b> <input type="checkbox"/> fever <input type="checkbox"/> rash <input type="checkbox"/> stiff neck <input type="checkbox"/> headache <input type="checkbox"/> other _____

**Please submit a separate form and specimen for each Test Panel**

Routine Syphilis	Arbovirus/WNV panel
<input type="checkbox"/> Routine RPR <input type="checkbox"/> VDRL(spinal fluid)	<input type="checkbox"/> Arbo IgG & IgM panel <input type="checkbox"/> WNV IgG & IgM <input type="checkbox"/> WNV IgM (CSF)
Special RPR testing request:	Hepatitis Testing
<input type="checkbox"/> Quantitative(Titer) and Confirmatory even if screening test (RPR) negative <input type="checkbox"/> No Confirmatory Test needed even if screening test (RPR) is positive <input type="checkbox"/> Quantitative (Titer) RPR  <input type="checkbox"/> List test for CDC referrals _____  <input type="checkbox"/> Special test requests _____	<input type="checkbox"/> Hep B (Prenatal) <input type="checkbox"/> Hep B (Routine Screen) <input type="checkbox"/> Anti-HAV Total Antibody <input type="checkbox"/> Anti-HAV-IgM <input type="checkbox"/> Anti-HCV
Miscellaneous Serology	
<input type="checkbox"/> Toxoplasmosis IgG <input type="checkbox"/> Toxoplasmosis IgM <input type="checkbox"/> Rubella IgG <input type="checkbox"/> Rubella IgM <input type="checkbox"/> CMV IgG <input type="checkbox"/> CMV IgM	<input type="checkbox"/> HSV1/HSV2 <input type="checkbox"/> Rubeola IgG <input type="checkbox"/> Rubeola IgM <input type="checkbox"/> Mumps <input type="checkbox"/> Varicella Zoster <input type="checkbox"/> Rocky Mountain Spotted Fever  <input type="checkbox"/> Murine Typhus <input type="checkbox"/> Torch Panel** <input type="checkbox"/> Other _____
<b>** TORCH panel</b> includes Toxoplasmosis, Rubella, CMV, HSV1/2	