

**Lab Use Only**

**Acceptance Criteria Not Met**

Inappropriate temperature

Specimen too old

Incomplete labeling/form

Specimen inappropriate/damaged

Date: \_\_\_/\_\_\_/\_\_\_ Initials: \_\_\_\_\_

# RUBELLA SEROLOGY

N.C. Department of Health and Human Services  
 State Laboratory of Public Health  
 4312 District Drive • P.O. Box 28047  
 Raleigh, NC 27611-8047

Please Give All Information Requested

Attach Printed Label Below

<b>Patient Information</b>	Last Name				
	First Name	MI			
	Maiden Name/Surname				
	Address/Attention:				
	Street Address:		Address 2:	City:	
	State:	Zip Code:	County Code:	County Name:	Phone Number:
	Insurance ID Number: (if applicable)		Medicaid Number (if applicable):		
	Medical Record Number:		Date of Birth: ___/___/___	If Female, Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Transgender M2F <input type="checkbox"/> Female <input type="checkbox"/> Transgender F2M <input type="checkbox"/> Unknown <input type="checkbox"/> Transgender Unknown <input type="checkbox"/> Ambiguous		Race (mark all that apply): <input type="checkbox"/> White <input type="checkbox"/> American Indian/ <input type="checkbox"/> Black Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/ <input type="checkbox"/> Unknown Pacific Isles		Ethnicity: <input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown
	Clinic/Program Type: <input type="checkbox"/> Prenatal <input type="checkbox"/> Family Planning <input type="checkbox"/> Other (specify): _____				
<b>Submitter</b>	EIN: _____		Submitter Name:		
	Address:		Address 2:	City:	
	State:		Zip Code:	County Name:	
	Phone Number:		Email Address:	Fax Number:	
	Ordering Provider NPI:		Ordering Provider First and Last Name:		
<b>Specimen</b>	Collection Date: ___/___/___	Collection Time: ___:___	Collector's Initials:		
	Specimen source: Serum		Reason for Testing (ICD-10 Dx Code):		
	Test ordered:  <b>Rubella IgG Antibody</b>		Laboratory Number:  <i>Do Not Write in this Space</i>		