Lab Use Only	
	☐ **Acceptance Criteria Not Met** ☐ Inappropriate temperature ☐ Specimen too old ☐ Incomplete labeling/form ☐ Specimen inappropriate/damaged Date: ____/____/_____ Initials:______

PARASITOLOGY

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*

Patient Information

Last Name			Attach Printed Label Below	
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: ____/____/________	
Sex: ❑ Male ❑ Transgender M2F ❑ Female ❑ Transgender F2M ❑ Unknown ❑ Transgender Unknown ❑ Ambiguous			Race (mark all that apply): ❑ White ❑ American Indian/ Alaska Native ❑ Black ❑ Asian ❑ Native Hawaiian/ Pacific Isles ❑ Unknown	Ethnicity: ❑ Hispanic or Latino Origin ❑ Non-Hispanic ❑ Unknown

Submitter

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:	

Specimen

Collection Date: ____/____/______ Collection Time: ___:___ 24 Hr Time	Reason for Testing (ICD-10 Dx Code): __ __ __ __ __ __ __
Specimen Source: ❑ Stool ❑ Other (specify) ____________________	Symptoms:
Test Ordered: ❑ **Intestinal Parasites Exam** ❑ **Cryptosporidium/Giardia** ❑ **Other ____________________**	Laboratory Number: *Do Not Write in this Space*

Other

Fill in if applicable:

If traveled outside U.S. within last five years, where? ______________________________

If Refugee, indicate nationality: ______________________________

Migrant? ❑ Yes ❑ No

For more information, refer to website at http://slph.ncpublichealth.com