Lab Use Only

☐ **Acceptance Criteria Not Met**
- ☐ Inappropriate temperature
- ☐ Specimen too old
- ☐ Incomplete labeling/form
- ☐ Specimen inappropriate/damaged

Date: ____/____/_____ Initials:_____

MYCOLOGY (FUNGUS)

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				
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
- ☐ Female
- ☐ Unknown
- ☐ Ambiguous
- ☐ Transgender M2F
- ☐ Transgender F2M
- ☐ Transgender Unknown

Race (mark all that apply):
- ☐ White
- ☐ Black
- ☐ Asian
- ☐ Unknown
- ☐ American Indian/ Alaska Native
- ☐ Native Hawaiian/ Pacific Isles

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 Type:
- ☐ Clinical Specimen
- ☐ Isolated Organism*

*(describe) _____

Specimen Source:
- ☐ Sputum ☐ Urine ☐ Bronchial ☐ Blood
- ☐ Other (specify)_____
- Exposure: _____
- Region of U.S._____
- Travel outside U.S.? ☐ Yes ☐ No
- Where? _____

Examine For:
- ☐ **Actinomycetes**
- ☐ **Mold**
- ☐ **Yeast**
- ☐ **Both (Mold & Yeast)**

Laboratory Number:

Do Not Write in this Space