

SYPHILIS 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

Lab Use Only

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

Date: ___/___/___ Initials: _____

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: ___/___/___	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 <input type="checkbox"/> Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/ <input type="checkbox"/> Unknown <input type="checkbox"/> 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"/> STD <input type="checkbox"/> Family Planning <input type="checkbox"/> Outreach <input type="checkbox"/> Student Health Services <input type="checkbox"/> Jail/Detention Centers <input type="checkbox"/> Other (specify): _____				
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: ___:___	Collector's Initials:		
	Specimen source: Serum		Reason for Testing (ICD-10 Dx Code):		
	Test ordered: <input type="checkbox"/> RPR (Titer and Confirmatory if Reactive) <input type="checkbox"/> Treponema pallidum confirmatory serology Specimen previously tested? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown RPR/TRUST result _____		Laboratory Number:		
	<i>Do Not Write in this Space</i>				
Other	Please mark Reason for Testing:				
	<input type="checkbox"/> Routine screening	<input type="checkbox"/> Contact to a known case	<input type="checkbox"/> Past history of syphilis		
<input type="checkbox"/> Prenatal	<input type="checkbox"/> Suspicious lesion	<input type="checkbox"/> Treatment follow-up			
<input type="checkbox"/> Neonatal screening	<input type="checkbox"/> Secondary symptoms/signs	<input type="checkbox"/> Other _____			