

HEPATITIS 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 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
	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 (continued on page 2)	Collection Date: ___/___/___		Collection Time: 24 Hr ___:___ Time	Collector's Initials	
	Specimen source: Serum		Reason for Testing (ICD-10 Dx Code): _____		
	Risk Factors (check all that apply) <input type="checkbox"/> Used drugs not as prescribed in last 6 months <input type="checkbox"/> Ever used drugs not as prescribed <input type="checkbox"/> Incarceration in last 6 months (if yes, _____ months) <input type="checkbox"/> History of incarceration prior to last 6 months <input type="checkbox"/> History of homelessness <input type="checkbox"/> Sexual contact with person who uses drugs <input type="checkbox"/> Anal sex following anal drug use <input type="checkbox"/> PReP patient		Laboratory Number:		
	Vaccination Status: HepA: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Incomplete HepB: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Incomplete		Do Not Write in this Space Reason for Hepatitis A Testing <i>must choose panel on back sheet</i> <input type="checkbox"/> Symptomatic with or without an epidemiologic link to a known HAV case <input type="checkbox"/> Confirmation of suspected case, with previous HAV positive result <input type="checkbox"/> Outbreak situation (prior approval required)*		

INSTRUCTIONS: Please check one panel (denoted by primary population). Hepatitis testing will reflect the panel markers indicated in the chart below. Make sure to print double sided or staple the two pages to prevent test ordering from separating from patient demographics.

HEPATITIS TESTING PANELS AND CORRESPONDING MARKERS

ORDER ONE	PANEL/POPULATION	MARKER				
		HBsAg ¹	Anti-HBcIgM ²	Anti-HBs ³	Anti-HBc ⁴	Anti-HAVIgM ⁵
<input type="checkbox"/>	HBV Prenatal; Refugee<18; Contact; Other (not listed) reason for testing	X	X if HBsAg (+)			
<input type="checkbox"/>	Hepatitis Symptomatic	X	X			X
<input type="checkbox"/>	HBV Risk Based	X	X if HBsAg (+)	X if HBsAg (-)		
<input type="checkbox"/>	HBV Previous Positive	X		X	X	
<input type="checkbox"/>	HBV Refugee ≥18 years (absent overseas documentation); Previous Positive, Acute	X	X if HBsAg (+)	X	X	
<input type="checkbox"/>	HBV Infant Follow-up	X		X		
<input type="checkbox"/>	HBV Infant Follow-up + Refugee<18	X	X if HBsAg (+)	X		
<input type="checkbox"/>	HBV Occupational Exposure (vaccinated healthcare worker)			X		
<input type="checkbox"/>	HAV Outbreak or Confirmation					X

¹HBsAg Hepatitis B Surface Antigen (Australia Antigen)

²Anti-HBcIgM IgM Antibody to Hepatitis B Core Antigen

³Anti-HBs Antibody to Hepatitis B Surface Antigen

⁴Anti-HBc Antibody to Hepatitis B Core Antigen

⁵Anti-HAVIgM IgM Antibody to Hepatitis A Virus

Comments:

*** Prior arrangements are required before submitting specimens for Hepatitis A outbreaks and other situations addressed above. To make arrangements, call (919) 733-3419; indicate on request form that such arrangements were made.**