

BT AND EMERGING PATHOGENS

N.C. Department of Health and Human Services
 State Laboratory of Public Health
 4312 District Drive
 Raleigh, NC 27607-8047 (FedEx/UPS only)

Lab Use Only

Acceptance Criteria Not Met

Inappropriate temperature

Specimen too old

Incomplete labeling

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: ___/___/___		
	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:			
Ordering Provider NPI:		Ordering Provider First and Last Name:			
Contact Name:		Contact Phone #:	Contact Fax #:		
Specimen	Collection Date: ___/___/___	Collection Time: 24 Hr ___:___ Time	Reason for Testing (ICD-10 Dx Code): _____		
	Specimen Type: <input type="checkbox"/> Isolated Organism (describe): _____ <input type="checkbox"/> Smear <input type="checkbox"/> Clinical		Specimen Source: <input type="checkbox"/> Blood <input type="checkbox"/> CSF <input type="checkbox"/> Urine <input type="checkbox"/> NP <input type="checkbox"/> Stool <input type="checkbox"/> Sputum <input type="checkbox"/> Wound Site: _____ <input type="checkbox"/> Other: _____		
	Examine For:		Laboratory Number:		
	<i>Do Not Write in this Space</i>				
Other	Clinical and/or Epidemiological Information:				
	Any Associated Illness: _____				
	Pertinent/Clinical/Lab Findings: _____				
Foreign or Domestic Travel? Where? _____ When? _____					