# 1332 Submission Form

**DEPARTMENT OF PUBLIC HEALTH**
**Public Health Laboratory**
**8231 Parklane Road Columbia, SC 29223**
**(803) 896-0800**

ALIGN BARCODE LABEL TO TOP OF BOX

| Patient's Name (Last) | (First) | (MI) | Sex | Ethnicity | Race | Date of Birth |
|---|---|---|---|---|---|---|
| | | | | | | |

| Address | City | State | Zip Code | County of Residence |
|---|---|---|---|---|
| | | | | |

| Phone Number | Country of Birth | MCI Number | Local ID | Clinic ID |
|---|---|---|---|---|
| | | | | |

| Sender No. | Sender Name | Billing Number | Program Number | Clinic Type |
|---|---|---|---|---|
| | | | | |

## Reason for Visit

- ☐ Contact
- ☐ Contact-Chlamydia
- ☐ Contact-Gonorrhea
- ☐ Contact-Hepatitis A
- ☐ Contact-Hepatitis B
- ☐ Contact-Hepatitis C
- ☐ Contact-HIV/HD/MD notified
- ☐ Contact-HIV Positive
- ☐ Contact-HIV/PT notified
- ☐ Contact-Syphilis
- ☐ Diagnosis
- ☐ Family Planning - Annual
- ☐ Family Planning – Initial
- ☐ Fast Track Ineligible
- ☐ Fast Track Services
- ☐ Follow-Up
- ☐ Pregnancy Test
- ☐ PrEP Testing Services
- ☐ Premarital (State______)
- ☐ Prenatal Visit
- ☐ Previous HIV Negative
- ☐ Previous HIV Positive
- ☐ Rapid Test Negative
- ☐ Rapid Test Positive
- ☐ Referral Agency
- ☐ Referred by outreach
- ☐ Referred by Drug Treatment Center
- ☐ Referred-Other
- ☐ Referred – Self
- ☐ Repeat Test/First Test___________
- ☐ Routine Screen
- ☐ Self-Report (Date: ____________)
- ☐ Special Project
- ☐ Survey
- ☐ Test of Cure
- ☐ Unknown
- ☐ Volunteer/Medical
- ☐ Workplace Exposure
- ☐ Other___________

## Serology Test Symptoms

Date of onset:
Fever:
Duration:
Rash (Type):

- ☐ Conjunctivitis
- ☐ Constipation
- ☐ Cough
- ☐ Diarrhea
- ☐ Headache
- ☐ Muscle Weakness
- ☐ Myocarditis
- ☐ Nuchal rigidity
- ☐ Paralysis
- ☐ Pericarditis
- ☐ Pharyngitis
- ☐ Pneumonia
- ☐ Rhinitis
- ☐ Vomiting

## Specimen Information

| Collection Date | Collection time | Ordering Physician, Provider and/or Nurse: |
|---|---|---|
| | ☐ AM ☐ PM | |

## Specimen Type

**Blood**
- ☐ Clotted
- ☐ ETDA-Lavender/Purple
- ☐ Finger, Heel
- ☐ Plasma
- ☐ Serum
- ☐ Venipuncture*

**Other**
- ☐ CSF
- ☐ Urine

* for Blood Lead Only

**Swab**
- ☐ Cervical
- ☐ Rectal
- ☐ Throat
- ☐ Unknown
- ☐ Urethral
- ☐ Vaginal
- ☐ Other ___________

## Risk History (Past 12 months)

**Client**

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9
☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 31 ☐ 32 ☐ 33

**Partner**

☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20 ☐ 21 ☐ 22 ☐ 23
☐ 24 ☐ 25 ☐ 26 ☐ 27 ☐ 28 ☐ 29 ☐ 30

## Chlamydia Test

| Pregnancy Status | Symptoms | Risk |
|---|---|---|
| ☐Yes ☐No ☐Unknown | ☐Yes ☐No ☐Unknown | ☐ Multiple partner ☐ New partner |

**Special Instructions and/or Comments:**

## Test Request

### Virology

- ☐ Mumps IgG
- ☐ Mumps IgM
- ☐ Rubella IgG
- ☐ Rubella IgM
- ☐ Rubeola IgG
- ☐ Rubeola IgM
- ☐ Chikungunya IgM
- ☐ Dengue IgM
- ☐ Varicella IgG
- ☐ West Nile IgM
- ☐ Zika IgM

### Analytical Chemistry

- ☐ Hg, Pb, Cd screen
- ☐ Lead (Blood)

Trace Heavy Metals (includes As, Be, Cd, Ba, TI, Pb, and U)*Individual metals upon request

- ☐ Biomonitoring-No Demographics

### Diagnostic Serology

| GC/CT Detection | ☐ GC and CT rRNA |
|---|---|
| Trichomonas Detection | Trichomonas rRNA |

Specimen type (Trichomonas):
☐ Urine ☐ Cervical ☐ Vaginal

### Diagnostic Serology

- ☐ Hepatitis A IgG
- ☐ Hepatitis B ImmuneStatus/post-immune
- ☐ HIV
- ☐ Hepatitis A IgM
- ☐ Hepatitis B Surface Antibody
- ☐ HIV Viral Load
- ☐ Hepatitis B Anti-Core
- ☐ Hepatitis B Surface Antigen
- ☐ HIV/Syphilis
- ☐ Hepatitis B Core Antibody IgM
- ☐ Hepatitis B Diagnostic Profile
- ☐ Hepatitis C Antibody
- ☐ Hepatitis C Viral Load
- ☐ PrEP Panel F/U (HIV, Syphilis, CT/GC)
- ☐ PrEP Panel Initial (HIV, Syphilis, CT/GC, Hep C+B)

Syphilis

## INSTRUCTIONS FOR COMPLETING REQUEST FORM

**(*May use printed patient lab label)***

1. Enter patient name.
2. Write M = Male; F = Female or TX = Transgender M2F (Male to Female); or TY = Transgender F2M (Female to Male) in Sex box.
3. Enter ethnicity as follows: H = Hispanic/Latino, N = Non-Hispanic/Latino and U = Unknown
4. Enter race as follows: A = Asian; B = Black/African American; W= White; I = American Indian/Alaskan Native; P = Native Hawaiian/Other Pacific Islander; O= Other; U = Unknown/Unclassified
5. Enter date of birth (month, day and year. Example: Enter 03/06/1960 for the birthday March 6, 1960.)
6. Enter the patient address and five-digit zip code.
7. Enter county of residence and the 10-digit telephone number.
8. Enter Country of Birth.
9. Fill in patient MCI ID number (DHEC Clients only).
10. Enter local and clinic ID if applicable. (Private clients must provide a clinic ID)
11. Enter Sender number and Sender name.
12. Enter billing number if billing number is different from sender number
13. Enter Program number.
14. Enter Clinic Type.
15. In the Reason for Visit/Test box, check all that apply. Enter Date of Onset if applicable and check all symptoms that apply.
16. Enter the date and time of collection.
17. Enter Ordering Physician, Provider and/or Nurse if applicable. **Note: Please print.**
18. Check type/source of specimen.
19. Use the codes below to identify client and partner Risk Factors during the **PAST 12 MONTHS**. (Circle all that apply)

| | |
|---|---|
| **CLIENT RISK** | **1**. Sex w/Female (F) **2**. Sex w/Male (M) **3**. Sex w/Transgender (T) **4**. Injection Drug Use (IDU)<br>**5**. Used non-injectable drug or alcohol anytime during past 12-months<br>**Received drugs/money in exchange for sex with a:** **6**. F/partner **7**. M/partner **8**. T/partner<br>**Had sex while high on drugs with a:** **9**. F/partner **10**. M/partner **11**. T/partner<br>**12**. Child of HIV infected mother **13**. Refused **14**. Other **31.** Without Condom<br>**32.** Oral Sex w/Female **33.** Oral sex w/Male |
| **PARTNER RISK** | **Client had sex with:**<br>**15**. F/IDU **16**. F/HIV + **17**. F/of unknown status **18**. F/who exchanges sex for drugs/money<br>**19**. F/who has transfusions/transplant recipient **20**. M/IDU **21**. M/HIV +<br>**22**. M/who exchanges sex for drugs/money **23**. Person who is a known MSM **(for female clients only)**<br>**24**. M/of unknown status **25**. M/who has transfusions/transplant recipient **26**. T/IDU **27**. T/HIV +<br>**28**. T/of unknown status **29**. T/who exchanges sex for drugs/money<br>**30**. T/who has transfusions/transplant recipient |

20. Chlamydia test: Check pregnancy status, risk, and symptom.
21. Enter Special Instructions and/or Comments.
22. Check test(s) requested.

**23.** Send one copy of the form with the specimen(s) to the lab. **Please Retain an Additional Copy For Your Records.**

Request forms will be retained following DPH records retention schedule 8581, "Requests for Laboratory Analysis", Records Group Number: 169.