1. Last Name | First Name | MI

2. Patient Number

3. Address

Zip Code

4. Date of Birth
Month | Day | Year

5. Race ☐ 1. White ☐ 2. Black ☐ 3. American Indian ☐ 4. Asian ☐ 5. Native Hawaiian/Pacific Islander ☐ 6. Unknown

6. Hispanic or Latino Origin: ☐ 1. Yes ☐ 2. No ☐ 3. Unknown

7. Sex ☐ 1. Male ☐ 2. Female

8. Co. of Residence

9. Medicaid Client ☐ Yes ☐ No
If yes, enter #

Dx Code/ICD-10:

Federal Tax No: ______________________

Send Report to:

Ordering Provider Name: ______________________

Provider NPI:

DO NOT WRITE IN THIS SPACE

LABORATORY NUMBER

DATE RECEIVED

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

SPECIMEN TYPE:
☐ CLINICAL SPECIMEN
☐ ISOLATED ORGANISM*
* Describe ______________________

DATE SPECIMEN COLLECTED
M | D | Y

EXAMINE FOR:
☐ MOLD
☐ YEAST

SPECIMEN SOURCE:
☐ SPUTUM ☐ URINE ☐ BRONCHIAL
☐ OTHER (*specify*) ______________________

TRAVEL INFORMATION:

MYCOLOGY (Fungus)

DHHS 2010 (Revised 07/2016)
Laboratory (Review 07/2019)

INSTRUCTIONS

PURPOSE: Isolation, identification, confirmation, further studies of human disease-producing yeasts or mold.

PREPARATION: Collect specimen by following instructions in SCOPE. Label each specimen tube or subculture with patient's name and your laboratory number if appropriate. Fill out this form and send in appropriate mailer with the specimen to State Laboratory of Public Health. Place form in ***outer*** container.
Do not send without label (patient's name and date of birth) on specimen or without form. Forms must be printed from our website at http://slph.ncpublichealth.com.

PREPARATION OF FORM: *Left Upper Portion of Form*. Item 1. Enter patient's name, last name first, first name, and middle initial or maiden name initial, if female. Item 2. Enter patient number (SSN or other unique number). Item 3. Enter patient's ***home*** address on lines immediately below. This information is required for epidemiologic follow-up. Item 4. Enter date of birth (not age). Items 5, 6, and 7. Indicate race, Hispanic ethnicity, and sex by checking appropriate box. These data are for statistical purposes only. Item 8. Enter county of residence of patient (use county code). Item 9. Indicate if patient is a Medicaid client; if yes, enter Medicaid number. Enter submitter federal tax number or social security number in blank. Also enter return address of submitter in box under “Send Report To.” Enter ordering provider name and provider NPI.

Right Upper Portion of Form. Specimen Type: Check appropriate box. Date Collected: Enter date as indicated. Specimen Source: Check appropriate box. Examine For: Suspected disease or type examination required. Travel Information: Give travel (foreign or domestic) in last five years.

DISPOSITION: This form may be destroyed in accordance with Standard 5, Patient Clinical Records, of the *Records Disposition Schedule* published by the N.C. Division of Archives and History.

DHHS 2010 (Revised 07/2016)
Laboratory (Review 07/2019)