1. Last Name | First Name | MI

2. Patient Number

Submitter Laboratory/Medical Record #: ____________________

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: ☐ ISOLATED ORGANISM** ☐ SMEAR ☐ CLINICAL*
*Fill out reverse of form

DATE SPECIMEN COLLECTED
M | D | Y

EXAMINE FOR:
☐ GC ☐ N. MENINGITIDIS GROUP ☐ H. INFLUENZAE TYPE
☐ BORDETELLA PCR ☐ BORDETELLA CULTURE ☐ LEGIONELLA DFA
☐ LEGIONELLA CULTURE ☐ REFERENCE ID**
**Describe organism, including biochemical reactions

SPECIMEN SOURCE:
☐ BLOOD ☐ CSF ☐ URINE ☐ SPUTUM ☐ NP ☐ BRONCH WASH
☐ BRONCH LAVAGE ☐ BRONCH BRUSH ☐ THROAT
☐ STERILE BODY FLUID ☐ WOUND–SITE ________________
☐ GENITAL–SITE__________ ☐ OTHER________________

SPECIAL/ATYPICAL BACTERIOLOGY

LABORATORY REPORT (DO NOT WRITE BELOW)

IDENTIFICATION

GRAM STAIN
OXIDASE
CATALASE

BILE ESCULIN
BILE SOLUBILITY
COAG.: SLIDE
TUBE
ESCULIN
GAS/GLU M.R.S.
LAP
MOTILITY
MR
NITRATE
PYR
PYRUVATE
UREA
VP

DECARBOXYLASES:
ARGININE
ORNITHINE

BASE:
ARABINOSE
FRUCTOSE
GLUCOSE
INULIN
LACTOSE
MALTOSE
MANNITOL
MANNOSE
RAFFINOSE
SORBITOL
SUCROSE
TREHALOSE
TURANOSE

DATE REPORTED: **By**

REPORT TELEPHONED TO: By

☐ DIRECT FA STAIN FOR ______________________________
☐ POSITIVE ☐ NEGATIVE (DFA STAIN IS A PRESUMPTIVE TEST)
☐ CULTURE FOR BORDETELLA ☐ POSITIVE ☐ NEGATIVE
☐ CULTURE FOR LEGIONELLA ☐ POSITIVE ☐ NEGATIVE
☐ PCR FOR BORDETELLA ☐ POSITIVE ☐ NEGATIVE

%NACL:	0%	6%	6.5%	8%	10%	
GROWTH TEMP.:	10C	25C	35C	42C	45C	
SEROLOGICAL GROUP:	A	B	C	D	F	G

ANTIBIOTIC DISCS:
VANCOMYCIN
POLYMYXIN B
NOVOBIOCIN
FURAZOLIDONE
OPTOCHIN

Comments:

DHHS 4121 (Revised 07/2016)
LABORATORY (Review 07/2019)

PLEASE PROVIDE THE FOLLOWING CLINICAL OR EPIDEMIOLOGIC INFORMATION

ANY ASSOCIATED ILLNESS_________________________ DATE OF ONSET _________________________

PERTINENT CLINICAL FINDINGS_________________________ SYMPTOMS _________________________

PREVIOUS LABORATORY RESULTS_________________________ _________________________

EPIDEMIOLOGICAL DATA: ☐SINGLE CASE ☐SPORADIC ☐CONTACT ☐EPIDEMIC ☐CARRIER ☐ANIMAL CONTACT _____________

FOREIGN OR DOMESTIC TRAVEL? WHERE? _________________ WHEN? (WITHIN LAST YEAR) _________________

OTHER ____

INSTRUCTIONS

PURPOSE: Isolation, identification, confirmation, further studies of human disease-producing aerobic bacteria.

PREPARATION: Collect specimen following instructions in SCOPE, using recommended collection kits. Label each specimen tube, subculture, or smear with patient's name and date of birth. 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 name) on specimen or without form. Forms must be printed from 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 (Health Departments use county code). Item 9. Indicate if patient is a Medicaid client; if yes, enter Medicaid number. Enter Diagnosis Code or ICD-10 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 in this box also.

Right Upper Portion of Form. Specimen Type: Check appropriate box. Date Specimen Collected: Enter date as indicated. Examine For: Suspected disease or type examination required. Specimen Source: Check appropriate box. Symptoms/Epidemiological Information: Check appropriate box(es). Provide any further information listed at top of this page.

Do not write in space below “Laboratory Report.”

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.