

[1] 1. Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

2. Patient Number (Soc. Security No.) \_\_\_\_\_ - H \_\_\_\_\_

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 # \_\_\_\_\_

# SEROLOGY

North Carolina  
 Department of Health and Human Services  
**State Laboratory of Public Health**  
 Leslie Wolf, PhD, Director  
 Virology/Serology Laboratory  
 306 North Wilmington Street • P.O. Box 28047  
 Raleigh, NC 27611-8047  
 Phone: (919) 733-7544  
 Fax: (919) 715-7700

[2] Federal Tax No.: \_\_\_\_\_

Send Report To: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Zip Code: \_\_\_\_\_

[3] SPECIMEN(S) SUBMITTED	[4] DATE COLLECTED	State Laboratory Number(s)
<input type="checkbox"/> ACUTE SERUM within 7 days of onset		
<input type="checkbox"/> CONVALESCENT SERUM		
<input type="checkbox"/> CSF		
[5] ONSET DATE	DATE RECEIVED	

[6] Physician Name: \_\_\_\_\_ Weekday Phone No.: \_\_\_\_\_ After-Hours Phone No.: \_\_\_\_\_ Fax Phone No.: \_\_\_\_\_

[7] **PATIENT SIGNS AND SYMPTOMS**

<b>GENITAL</b> <input type="checkbox"/> Vesicles <input type="checkbox"/> PID <input type="checkbox"/> Cervicitis <input type="checkbox"/> Urethritis <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Mucopurulent discharge <input type="checkbox"/> Atypical Lesion	<b>RASH</b> <input type="checkbox"/> Macular <input type="checkbox"/> Papular <input type="checkbox"/> Vesicular <input type="checkbox"/> Petechial <input type="checkbox"/> Focal <input type="checkbox"/> Hemorrhagic	<b>RESPIRATORY</b> <input type="checkbox"/> Cough <input type="checkbox"/> Pneumonia <input type="checkbox"/> Bronchitis <input type="checkbox"/> Croup <input type="checkbox"/> Pharyngitis	<b>CNS</b> <input type="checkbox"/> Seizures <input type="checkbox"/> Meningitis <input type="checkbox"/> Encephalitis <input type="checkbox"/> Nuchal rigidity <input type="checkbox"/> Paralysis	<b>CARDIOVASCULAR</b> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Pericarditis <input type="checkbox"/> Myocarditis <input type="checkbox"/> Pleurodynia <b>GASTROINTESTINAL</b> <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Diarrhea	<b>GENERAL</b> <input type="checkbox"/> Fever to _____ ° <input type="checkbox"/> Headache <input type="checkbox"/> Fatigue <input type="checkbox"/> Sore Throat <input type="checkbox"/> Jaundice <input type="checkbox"/> Conjunctivitis
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[8] Recent Vaccination History: \_\_\_\_\_ Travel History: \_\_\_\_\_

### INFECTIOUS AGENT(S) SUSPECTED AND TEST(S) REQUESTED

<b>Serologic Diagnostic Panels Available:</b> <i>(Check one or more boxes, as needed)</i> <input type="checkbox"/> Arboviral Panel (Eastern Equine Encephalitis, Western Equine Encephalitis, St. Louis Encephalitis, La Crosse Encephalitis and West Nile) <input type="checkbox"/> Rickettsia Panel (Rickettsia rickettsii, Rickettsia typhi, Ehrlichia species)	<b>Single Agent Diagnostic Tests:</b> <i>(Check one or more boxes, as needed)</i> <input type="checkbox"/> Human Immunodeficiency Virus 1 (HIV-1) confirmatory <input type="checkbox"/> Q-fever <input type="checkbox"/> <i>Treponema pallidum</i> confirmatory serology (CAPITIA syphilis <i>T. pallidum</i> -G) <input type="checkbox"/> Other: _____ _____ _____
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Exanthems:  
 Measles, Rubella  
 Varicella Zoster  
 Mumps

*(All suspect cases should be called to Immunization prior to submission of specimen to State Lab. Immunization can be reached at 919-707-5550.)*

Prior approval/consultation received from: \_\_\_\_\_

Please forward specimen to CDC for testing. (Attach a completed CDC form. See "SCOPE: A Guide to Laboratory Services" for instructions).

## Instructions for Completion of this Form and Serological Specimen Submission

### Specimen Acceptance Policy:

Serologic testing is routinely performed only on serum. CSF will be tested in special cases if accompanied by a companion serum collected at the same time. Serologic assays are performed for a variety of bacterial, parasitic, rickettsial and viral agents. Usually an acute and convalescent phase serum are required for diagnostic tests. Please freeze and hold the acute serum for submission to the laboratory at a later date with the convalescent serum. The laboratory offers single serum diagnostic testing in the case of measles, rubella, rickettsial, or arboviral agents where testing of the initial serum might prove diagnostically useful. Diagnostic serologic services are available to both public and private health care providers.

Immune status testing for measles, mumps, rubella, or varicella is not available on a routine basis. Exceptions to this policy apply only to local health departments and include the following:

1. Rubella immune status testing is limited to prenatal patients with no documentation of vaccination or previous immune status testing. (Use form DHHS 1188).
2. "Stat" varicella zoster virus (VZV) immune status testing is available for prenatal clients **only** who **lack a clear history of varicella zoster infection or whose immune status is unknown and have been exposed to a known case of VZV**. In cases in which testing is appropriate and results are urgently needed, the submitter must contact the Women's Health Nurse Consultant or Maternal Health Nurse Consultant to arrange for testing at the State Laboratory. The Consultant will then contact either the Virology/Serology Unit Supervisor or the Special Serology Laboratory Supervisor at (919) 733-7544 so that testing can be scheduled for timely results, preferably during normal business hours. Provide **a contact name and telephone number** for the person who is to receive the test result.
3. Immune status testing for measles is available for clients when vaccination is contraindicated (e.g., pregnancy, immunosuppression, or allergy to vaccine components). Reason for contraindication **must** be noted on the test request.

### Specimen Collection, Packaging and Shipment:

1. To collect serum, draw blood into a red top vacuum tube, serum separator tube, or equivalent and let stand for 30 minutes to ensure complete clotting of the blood. Centrifuge the sample for 5-10 minutes at  $\geq 1,000 \times G$ .
2. Transfer the serum to a plastic screw-capped vial available from the State Laboratory. (Hemolyzed, icteric, or lipemic serum may be unacceptable for certain serologic assays.)
3. Clearly label each specimen vial with the **patient's first and last name, either date of birth or SSN**, type of specimen if not serum, and collection date. (Specimens without names or incorrectly labeled will not be tested).
4. To avoid testing delays, completely fill out all items in Sections 1 through 8 of the form and select the desired tests.
5. Package the labeled tubes with absorbent material inside of a secondary leak proof container.
6. Ship the properly identified vials of patient sera and completed test request form in the blue colored "SPECIAL SEROLOGY" mailing containers or their equivalent.
7. Additional serum transport tubes and blue colored specimen mailers are available through the NCSLPH online supply ordering system on our Web site at <http://slph.ncpublichealth.com>.
8. For further information, see "SCOPE, A Guide to Laboratory Services" on our Web site at <http://slph.ncpublichealth.com> or contact the Virology/Serology Laboratory at (919) 733-7544.

### Interpretation of Serological Results:

Failure to detect a significant antibody response may be the result of a number of factors including: improperly collected specimens, specimens collected at a period in the disease when the patient is not responding immunologically, selection of the incorrect infectious agent for testing, or lack of sensitivity in the serological system being used.