1. Last Name | First Name | MI

2. Patient Number (Soc. Security No.)

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 If yes, enter # ☐ No

Federal Tax No.: _____

Send Report To:

Contact Name: _____

Phone: _____

Fax: _____

Ordering Physician: _____

Ordering Physician's Phone: _____

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

DATE SPECIMEN COLLECTED:

SPECIMEN TYPE: ☐ ISOLATED ORGANISM* ☐ SMEAR ☐ CLINICAL**

EXAMINE FOR: _____

*Describe organism _____

SPECIMEN SOURCE:
☐ BLOOD ☐ CSF ☐ URINE ☐ SPUTUM ☐ NP ☐ STOOL
☐ WOUND-SITE ☐ OTHER _____

BT and Emerging Pathogens

SPECIMEN UNSATISFACTORY:
☐ BROKEN/LEAKED IN TRANSIT ☐ SPECIMEN UNLABELED
☐ QUANTITY INSUFFICIENT ☐ SPECIMEN IMPROPERLY PREPARED
☐ NO SPECIMEN ☐ FORM IMPROPERLY PREPARED

**PROVIDE THE FOLLOWING CLINICAL AND/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 and/or further studies of suspected agents of bioterrorism or emerging pathogens.

PREPARATION: PRIOR TO SUBMISSION, call 919-807-8600 for guidance on collection (information can be found in SCOPE), transport of samples and package labeling. Label each specimen tube, subculture or smear with patient's name and social security number or date of birth. Complete this form and submit with the specimen following current shipping guidelines. Place form in outer container. Do not send specimen without labeling or submit without completed form. Forms are available at http://slph.ncpublichealth.com/bioterrorism/default.asp#subform.

PREPARATION OF FORM:
Left upper portion of Form: Item 1: Enter patient's name, last name first and middle initial or maiden name initial, if female. Item 2: Enter patient's social security number. ***This is the identifying number for that patient.*** If the patient has no social security number, please indicate on form. 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, 7: Indicate race, Hispanic ethnicity and sex by checking the appropriate box. These data are for statistical purposes only. Item 8: Enter County of residence of patient. Item 9: Indicate if patient is a Medicaid client; if yes, enter Medicaid number. Enter Submitter federal tax identification number in the space provided. Enter the return address of the submitter in the "Send Report To" area. Provide contact name, telephone and fax number of individual responsible for the specimen. Enter the name and contact information of the ordering physician.

Right Upper Portion of Form: Enter date specimen collected. Specimen Type: Check appropriate box. Examine For: Enter suspected organism or type of examination required. Describe organism if from an isolated organism. Specimen Source: Check appropriate box.

Middle Portion of Form: Symptoms/Epidemiological Information: Provide any further clinical and/or epidemiological information if testing is for a clinical sample. Check appropriate box(es).

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.