

Web Portal

Instructions on creating an electronic test requisition



User:

Pwd:

Loc:

Login

[Forgot Password](#)

[Enrollment Request](#)

Welcome to the Georgia Public Health Laboratory Web Portal



Press Releases:

Information is provided by Georgia State Department of Public Health

Enter your assigned User ID, Password and Location Code (LOC).
Your **USER ID** and **LOC Code** need to be entered in **ALL CAPS**.
- Click Login



User: NICH 
Site: TEST

- Main**
- Patient Registration
- Order Entry**
- Batch Build
- Batch Print
- Label Print
- Inquiry
- Reporting
- Pending
- Admin
- User Guide

Log Out

Welcome to the Georgia Public Health Laboratory Web Portal



[What's New:](#) [Lab Dir:](#)

Important Changes to HCV Viral Load Assay:

[Letter to Apollo Submitters \(Test Change\)](#)

Important Changes to HIV-1 Viral Load Assay:

[Letter to Apollo Submitters \(Test Change\)](#)

08/13/2021

It has come to our attention that there has been an increase in samples received at room temperature outside of the acceptable time period. Therefore, we wanted to take the opportunity to send a reminder to all submitters regarding the specimen requirements for use with our current HIV assays. This is a CLIA requirement and we will have to reject samples that are not submitted in adherence to the manufacturer's instructions. Per assay package insert: Serum or plasma specimens should be stored for no longer than 3 days at room temperature or 7 days at 2 to 8°C following specimen collection. If a storage period greater than 7 days is anticipated, the specimens should be removed from the clot, red blood cells, or separator gel and the serum or plasma should be stored frozen at -20°C. Please note that the storage time includes the time that samples are in transit. Therefore, if samples cannot be received at GPHL within 72 hours, samples should be transported on cold packs.

Information is provided by Georgia State Dept of Public Health

This is your Main Page.
From here you will select:
Order Entry.



- User: NICH 
Site: TEST
- Main
 - Patient Registration
 - Order Entry**
 - Batch Build
 - Batch Print
 - Label Print
 - Inquiry
 - Reporting
 - Pending
 - Admin
 - User Guide

Log Out



GEORGIA PUBLIC HEALTH LABORATORY SUBMISSION FORM

Complete a separate form for each test requested

Lab #:   

Save Print

Choose Lab to Perform Test
 Decatur Waycross

HEALTH CARE PROVIDER INFORMATION	PATIENT INFORMATION	
<p>Submitter Code: <input type="text"/> COPYTO Code: <input type="text"/></p> <p>TEST: TEST SUBMIT <input type="button"/></p> <p>Submitter Name: <input type="text"/></p> <p>Address: <input type="text"/></p> <p>City: <input type="text"/> State: <input type="text"/> Zip: <input type="text"/></p> <p>Phone Number: <input type="text"/></p> <p>Fax Number: <input type="text"/></p> <p>Contact Name: <input type="text"/></p>	<p>Patient ID Number: <input type="text"/> Patient Number (LAB Unique ID): <input type="text"/></p> <p>PATIENT NAME (Last, First MI, Suffix): <input type="text"/></p> <p>County of Residence: <input type="text"/> DOB: <input type="text"/></p> <p>Phone # (Home): <input type="text"/> Phone # (Work): <input type="text"/> Phone # (Cell): <input type="text"/></p> <p>Address, City, State Zip: <input type="text"/></p> <p>Parent / Guardian (if applicable): <input type="text"/> Relationship: <input type="text"/></p> <p>Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black/African-American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White / Caucasian <input type="checkbox"/> Multi Racial <input type="checkbox"/> Asian</p> <p>Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino</p> <p>Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p>	
<p><input type="checkbox"/> SELF PAY (Submitter will be invoiced) APPROVAL CODE: <input type="text"/> (Submitter will be billed if a valid code is not provided)</p>		
<p>INSURANCE INFORMATION - COPY OF PATIENT'S INSURANCE ELIGIBILITY DOCUMENT MUST BE SUBMITTED WITH THIS FORM</p>		
<p>FOR FUTURE USE</p>		
<p>TEST REQUESTED <small>*All tests are performed at the Decatur Laboratory unless specified.*</small></p>		
<p>BLOOD LEAD <i>(Waycross Only)</i></p> <p><input type="checkbox"/> W40500 Waycross</p> <p>COLLECTION METHOD</p> <p><input type="checkbox"/> Capillary <input type="checkbox"/> Venous</p> <p>MOLECULAR BIOLOGY <i>(Decatur Only)</i></p> <p>Consultation with epidemiologist required.</p> <p><input type="checkbox"/> 423000 2018-nCoV RT-PCR Panel BT agent rule out (RT-PCR)</p> <p><input type="checkbox"/> BTC01000b Bacillus anthracis <input type="checkbox"/> BTC02000 Brucella spp. <input type="checkbox"/> BTC03000 B.mallei/pseudomallei <input type="checkbox"/> BTC04000 Francisella tularensis</p>	<p>CHEMICAL THREAT <i>(Decatur Only)</i></p> <p>Consultation with GPHL Emergency Response Coordinator required.</p> <p>24/7 contact number: 404-855-3895 888-782-4584</p> <p><input type="checkbox"/> CT041100 Rapid Tox Screen (RTS) <i>(Performed at the CDC)</i></p> <p><input type="checkbox"/> CT021500 Cadmium, mercury and lead (blood)</p> <p><input type="checkbox"/> CT021700 Toxic Element Screen (TES) (urine) <i>(As, Ba, Be, Cd, Pb, Tl, U)</i></p> <p><input type="checkbox"/> CT021800 Mercury (urine)</p>	<p>MYCOBACTERIOLOGY</p> <p>Known TB Patient? <input type="checkbox"/> Current <input type="checkbox"/> Former <input type="checkbox"/> No</p> <p>Clinical Specimens</p> <p><input type="checkbox"/> 30100 Microscopic exam for AFB only</p> <p><input type="checkbox"/> 30000 Smear, Culture & Susceptibility testing <i>(Susceptibility Performed on MTB only)</i></p> <p><input type="checkbox"/> 30800 Nucleic Acid Amplification Testing (NAAT) <i>This test is intended for use only with specimens from tubercle infected patients showing signs and symptoms of active pulmonary tuberculosis.</i></p> <p>AFB Isolates</p> <p><input type="checkbox"/> 34000 Identification</p> <p><input type="checkbox"/> 33950 Susceptibility testing (MTB only)</p> <p><input type="checkbox"/> 30750 Genotyping only</p>

To begin Order Entry click the **GREEN +**.



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Site: TEST

- Main
- Patient Registration
- Order Entry**
- Batch Build
- Batch Print
- Label Print
- Inquiry
- Reporting
- Pending
- Admin
- User Guide

Log Out



GEORGIA PUBLIC HEALTH LABORATORY SUBMISSION FORM

Complete a separate form for each test requested

Lab #: 22B003028!

Save

Print

Choose Lab to Perform Test

Decatur

Waycross

HEALTH CARE PROVIDER INFORMATION

PATIENT INFORMATION

Submitter Code TEST: TEST SUBMIT	COPYTO Code	Patient ID Number	Patient Number (LAB Unique ID):
Submitter Name TEST SUBMITTER		PATIENT NAME (Last, First MI, Suffix)	
Address		County of Residence	DOB
City	State	Phone # (Home)	Phone # (Work)
	Zip		Phone # (Cell)
Phone Number		Address, City, State Zip	
Fax Number		Parent / Guardian (if applicable)	Relationship
Contact Name		Race	Ethnicity
		<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Hispanic or Latino
		<input type="checkbox"/> Black/African-American	<input type="checkbox"/> Non-Hispanic or Latino
		<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> Male
		<input type="checkbox"/> White / Caucasian	<input type="checkbox"/> Female
		<input type="checkbox"/> Multi Racial	<input type="checkbox"/> Asian
		Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
<input type="checkbox"/> SELF PAY (Submitter will be invoiced)		APPROVAL CODE:	(Submitter will be billed if a valid code is not provided)

INSURANCE INFORMATION - COPY OF PATIENT'S INSURANCE ELIGIBILITY DOCUMENT MUST BE SUBMITTED WITH THIS FORM

FOR FUTURE USE

TEST REQUESTED

All tests are performed at the Decatur Laboratory unless specified.

Once you click the **GREEN +**, Your **facility** and **submitter code** information, as well as a **Lab #** (22B#) will auto-populate into the submission form.



GEORGIA PUBLIC HEALTH LABORATORY SUBMISSION FORM

Complete a separate form for each test requested

Lab #: 22B003028

Save

Print

Choose Lab to Perform Test

Decatur Waycross

HEALTH CARE PROVIDER INFORMATION

Submitter Code: TEST: TEST SUBMIT

Submitter Name: TEST SUBMITTER

Address:

City: State: Zip:

Phone Number:

Fax Number:

Contact Name:

SELF PAY (Submitter will be invoiced)

INSURANCE INFORMATION - COPY OF PATIE

PATIENT INFORMATION

Patient ID Number: Patient Number (LAB Unique ID):

PATIENT NAME (Last, First MI, Suffix):

County of Residence: DOB:

Phone # (Home): Phone # (Work): Phone # (Cell):

Address, City, State Zip:

User: NICH

Site: TEST

Main

Patient Registration

Order Entry

Batch Build

Batch Print

Label Print

Inquiry

Reporting

Pending

Admin

User Guide

Log Out



User: NICH

Site: TEST

Main

Patient Registration

Order Entry

Batch Build

Batch Print

Label Print

Inquiry

Reporting

Pending

Admin

User Guide

Log Out

To enter a new patient, select the pencil.

GEORGIA PUBLIC HEALTH
LABORATORY SUBMISSION FORM

Complete a separate form for each test requested

Lab #: 22B003028

Save Print

Choose Lab to Perform Test
 Decatur Waycross

HEALTH CARE PROVIDER INFORMATION

Submitter Code: TEST: TEST SUBMIT

Submitter Name: TEST SUBMITTER

HEALTH CARE PROVIDER INFORMATION

Submitter Code: TEST: TEST SUBMIT

Submitter Name: TEST SUBMITTER

PATIENT INFORMATION

Patient ID Number: 123456 Patient Number (LAB Unique ID): 2198353

PATIENT NAME (Last, First MI, Suffix):

County of Residence: DOB:

Phone # (Home): Phone # (Work): Phone # (Cell):

Address, City, State Zip:

SELF PAY (Submitter will be invoiced)

INSURANCE INFORMATION - COPY OF PATIE

TEST REQUESTED

[Patient Registration]

User Id: NICH Site Id: TEST

Unique ID: 2198353

Demographics Guarantor Insurance

*Patient First Name: TEST *Last: TEST

*Race: UNKNOWN *Ethnicity: Unknown

*Sex/Gender: Female *Date of Birth: 01/01/2001

Patient Address:

City State Zip:

Patient Phone #:

*Patient ID: 123456

Billing Acct #:

Active

Cancel Save

Once you select the pencil, the Patient Registration box will pop-up.

You will need to fill in the required information highlighted with a red star*. Once you have completed entering in the patient information, Select SAVE.

You will then return to the Submission form.



GEORGIA PUBLIC HEALTH LABORATORY SUBMISSION FORM

Complete a separate form for each test requested

Lab #:

Choose Lab to Perform Test

Decatur Waycross

User: NICH
Site: TEST

- Main
- Patient Registration
- Order Entry
- Batch Build
- Batch Print
- Label Print
- Inquiry
- Reporting
- Pending
- Admin
- User Guide

HEALTH CARE PROVIDER INFORMATION		PATIENT INFORMATION	
Submitter Code <input type="text" value="TEST: TEST SUBMIT"/>	COPYTO Code <input type="text" value="TEST SUBMITTER"/>	Patient ID Number <input type="text" value="123456"/>	Patient Number (LAB Unique ID) <input type="text" value="2198353"/>
Submitter Name <input type="text" value="TEST SUBMITTER"/>		PATIENT NAME (Last, First MI, Suffix) <input type="text" value="TEST TEST"/>	
Address <input type="text"/>		County of Residence <input type="text"/>	DOB <input type="text" value="01/01/2001"/>
City <input type="text"/>	State <input type="text"/>	Zip <input type="text"/>	Phone # (Home) <input type="text"/>
Phone Number <input type="text"/>	Fax Number <input type="text"/>	Phone # (Work) <input type="text"/>	Phone # (Cell) <input type="text"/>
Contact Name <input type="text"/>	Parent / Guardian (if applicable) <input type="text"/> Relationship <input type="text"/>		
Race <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black/African-American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White / Caucasian <input type="checkbox"/> Multi Racial <input type="checkbox"/> Asian		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino	
Sex <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female		Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	

Once you return to the Submission Form, you will notice that your patient's information has been filled in.

Next, you need to select the test code to order on your patient.

PATIENT NAME		Lab Specimen #: 22B0030285
Last: <input type="text" value="TEST"/> First: <input type="text" value="TEST"/> MI: <input type="text"/>		
BACTERIOLOGY		
Enteric Isolates <input type="checkbox"/> 1100 Campylobacter <input type="checkbox"/> 1070 STEC <input type="checkbox"/> 1110 Salmonella <input type="checkbox"/> 1080 Shigella <input type="checkbox"/> 1180 Yersinia <input type="checkbox"/> 1120 Stool Culture - Preserved (Para-Pak C&S, Room Temp) <input type="checkbox"/> Routine (Salmonella, Shigella, Campylobacter, Aeromonas, STEC and Yersinia) <input type="checkbox"/> S. aureus [1] <input type="checkbox"/> 1140 Stool Culture - Fresh (Refrigerated) <input type="checkbox"/> B. cereus [1] <input type="checkbox"/> C. perfringens [1] <input type="checkbox"/> 1130 Special Bacterology <input type="checkbox"/> Neisseria meningitidis <input type="checkbox"/> Haemophilus influenzae <input type="checkbox"/> Listeria monocytogenes <input type="checkbox"/> Vibrio sp. <input type="checkbox"/> Other - Suspected agent <input type="checkbox"/> 1040 Pertussis Direct Fluorescent Antibody (DFA) <input type="checkbox"/> 1050 Pertussis Culture <input type="checkbox"/> 1030 Group A Streptococcus <input type="checkbox"/> 1010 Gonorrhea Culture <input checked="" type="checkbox"/> Nucleic Acid Amplification Test (Chlamydia/Gonorrhea) <input type="checkbox"/> 1060 Decatur <input type="checkbox"/> W10000 Waycross <input type="checkbox"/> Nucleic Acid Amplification Test (Trichomonas vaginalis) <input type="checkbox"/> 100100 Decatur <input type="checkbox"/> W100100 Waycross <input type="checkbox"/> 1135 Forward to the CDC [1] <input type="text"/> <input type="checkbox"/> C. botulinum [1],[2]		
IMMUNOLOGY		
(Choose nearest location)		
Routine RPR (Syphilis) <input type="checkbox"/> 1610 Decatur <input type="checkbox"/> W20000 Waycross <input type="checkbox"/> 1630 VDRL (spinal fluid) <input type="checkbox"/> 1640 TPPA Quantitative (Titer) and Confirm even if RPR is negative <input type="checkbox"/> 16102 Decatur <input type="checkbox"/> W20100 Waycross RPR - No Confirmation test even if RPR is positive <input type="checkbox"/> 16101 Decatur <input type="checkbox"/> W20300 Waycross Arbovirus / WNV panel <input type="checkbox"/> 1595 Arbo IgG <input type="checkbox"/> 1600 Arbo IgM <input type="checkbox"/> 1580 WNV IgG <input type="checkbox"/> 1585 WNV IgM <input type="checkbox"/> 1590 WNV IgM (CSF) Hepatitis Testing <input type="checkbox"/> 1411 Hep B (Prenatal) <input type="checkbox"/> 1470 HCV Antibody <input type="checkbox"/> 1410 Hep B (Routine Scrn) <input type="checkbox"/> 1480 HCV Screening <input type="checkbox"/> 1635 Quantitative HBV <input type="checkbox"/> 1400 Anti HAV Total <input type="checkbox"/> 1405 Anti HAV IgM <input type="checkbox"/> 14101 TORCH Panel <input type="checkbox"/> 16300 Toxoplasmosis IgG <input type="checkbox"/> 16350 Toxoplasmosis IgM <input type="checkbox"/> 16100 Rubella IgG <input type="checkbox"/> 16150 Rubella IgM <input type="checkbox"/> 16450 CMV IgG <input type="checkbox"/> 16500 CMV IgM <input type="checkbox"/> 16600 HSV1 <input type="checkbox"/> 16650 HSV2		

For example:
For Chlamydia/Gonorrhea testing, SELECT test code 1060 under the Bacteriology Section. See [circled area](#).

User: NICH
Site: TEST

- Main
- Patient Registration
- Order Entry
- Batch Build
- Batch Print
- Label Print
- Inquiry
- Reporting
- Pending
- Admin
- User Guide

Log Out

[1] Special arrangement required CALL 404-327-7997

User: NICH Site: TEST

- 1180 Yersinia
- 1120 Stool Culture - Preserved (Para-Pak C&S, Room Temp)
 - Routine (Salmonella, Shigella, Campylobacter, Aeromonas, STEC and Yersinia)
 - S. aureus [1]
- 1140 Stool Culture - Fresh (Refrigerated)
 - B. cereus [1]
 - C. perfringens [1]
- 1130 Special Bacteriology
 - Neisseria meningitidis
 - Haemophilus influenzae
 - Listeria monocytogenes
 - Vibrio sp.
 - Other - Suspected agent
- 1040 Pertussis Direct Fluorescent Antibody (DFA)
- 1050 Pertussis Culture
- 1030 Group A Streptococcus
- 1010 Gonorrhoea Culture
- Nucleic Acid Amplification Test (Chlamydia/Gonorrhoea)
 - 1060 Decatur W10000 Waycross
- Nucleic Acid Amplification Test (Trichomonas vaginalis)
 - 100100 Decatur W100100 Waycross
- 1135 Forward to the CDC [1]
 - C. botulinum [1],[2]

[1] Special arrangement required CALL 404-327-7997
 [2] Epidemiology approval required CALL 404-657-2588

1180 ENVIRONMENTAL / FOOD (Epidemiology Use Only)

- B. cereus STEC / SLT
- Campylobacter Salmonella
- C. perfringens Shigella
- Listeria S. aureus

Quantitative (Titer) and Confirm even if RPR is negative

- 16102 Decatur W20100 Waycross

RPR - No Confirmation test even if RPR is positive

- 16101 Decatur W20300 Waycross

Arbovirus / WNV panel

- 1595 Arbo IgG
- 1800 Arbo IgM
- 1580 WNV IgG
- 1585 WNV IgM
- 1590 WNV IgM (CSF)

Hepatitis Testing

- 1411 Hep B (Prenatal) 1470 HCV Antibody
- 1410 Hep B (Routine Scrn) 1480 HCV Screening
- 1490 HCV Viral Load
- 1635 Quantitative HBV
- 1400 Anti HAV Total
- 1405 Anti HAV IgM

14101 TORCH Panel

- 15300 Toxoplasmosis IgG
- 15350 Toxoplasmosis IgM
- 15100 Rubella IgG
- 15150 Rubella IgM
- 15450 CMV IgG
- 15500 CMV IgM
- 15600 HSV1
- 15650 HSV2

Miscellaneous Serology

- 15550 Mumps 14100 MMR Panel
- 15200 Rubella IgG 1525 Rubella IgM
- 15400 Varicella Zoster
- 34900 QuantiFERON-TB Gold IGRA
- 1570 Forward to the CDC

After selecting the test code, scroll to the bottom of the page and fill in the Specimen Information. Use the drop-down box to select the Specimen Type, then Fill in Date and Time of Collection.

Once you have entered all the Specimen Information click SAVE.

You will then be asked how many labels you want to print. If you do not have a Dymo label printer set-up, enter "0" and Select OK.

VIROLOGY

HIV

CTS #

- 13700 HIV Ag/Ab Combo
- 1360 HIV-1 Ab WB (DBS only)
- 13550 HIV-1 RNA Qual (early infection)
- 1340 HIV-1 Viral Load
- 35000 Genotype (Program Approved)
- 36000 Integrase (Program Approved)

VIRAL CULTURE

- 62050 CMV Culture / IFA
- 60000 Mumps Culture / IFA
- 1385 Enterovirus Culture / IFA
- 15700 Herpes virus 1&2 by NAAT
- 62000 VZV Culture / IFA
- 6100 Respiratory Culture / IFA
- 1375 Influenza Culture / IFA
- 60040 Viral Culture/Identification

Gastrointestinal Outbreak Invest.

- 6030 Rotavirus EIA

Misc. Virology Send-out

- 60160 Virology CDC Sendout
- 42390 SARS-CoV-2 sequencing
- 171000 Respiratory Viral Panel
- 433000 CDC Influenza SARS-CoV-2 (Flu SC2) Multiplex

All tests are performed at the Decatur Laboratory unless specified.

SPECIMEN INFORMATION

Specimen Type:

Specimen Source:

Body Site:

SHIPPED

- Frozen
- Refrigerated
- Room Temperature

Date of Onset:

Symptoms:

Specimen Notes:

Date of Collection:

Time of Collection:

Outbreak? Yes No
If yes, name of outbreak:

Travel? Yes No
If yes, Where?

COVID PUI #

apollo.dph.ga.gov says

Enter # of Labels:

BACTERIOLOGY

IMMUNOLOGY

ENTERIC ISOLATES

- 1100 Campylobacter
- 1070 STEC
- 1110 Salmonella
- 1030 Shigella
- 1180 Yersinia

ROUTINE RPR (Syphilis)

- 1610 Decatur W2000
- 1630 VDRL (spinal fluid)
- 1640 TRPA

QUANTITATIVE (TITER) AND CONFIRM EVEN IF RPR IS POSITIVE

- 16102 Decatur W2010

ARBOVIRUS / WNV PANEL

- 1595 Arbo IgG
- 1800 Arbo IgM
- 1580 WNV IgG
- 1585 WNV IgM
- 1590 WNV IgM (CSF)

HEPATITIS TESTING

- 1411 Hep B (Prenatal) 1470 HCV Antibody
- 1410 Hep B (Routine Scrn) 1480 HCV Screening
- 1490 HCV Viral Load
- 1635 Quantitative HBV
- 1400 Anti HAV Total
- 1405 Anti HAV IgM

14101 TORCH PANEL

- 15300 Toxoplasmosis IgG
- 15350 Toxoplasmosis IgM
- 15100 Rubella IgG
- 15150 Rubella IgM
- 15450 CMV IgG
- 15500 CMV IgM
- 15600 HSV1
- 15650 HSV2

MISCELLANEOUS SEROLOGY

- 15550 Mumps 14100 MMR Panel
- 15200 Rubella IgG 1525 Rubella IgM
- 15400 Varicella Zoster
- 34900 QuantiFERON-TB Gold IGRA
- 1570 Forward to the CDC

Once you Select OK for labels, the screen will clear and you will be able to start a new patient or build a batch.



GEORGIA PUBLIC HEALTH LABORATORY SUBMISSION FORM

Complete a separate form for each test requested

Lab #: 22B003030;  

Save  Print 

Choose Lab to Perform Test
 Decatur Waycross

HEALTH CARE PROVIDER INFORMATION **PATIENT INFORMATION**

Submitter Code: TEST: TEST SUBMIT COPYTO Code: Patient ID Number: Patient Number (LAB Unique ID):  

Submitter Name: TEST SUBMITTER PATIENT NAME (Last, First MI, Suffix):

Address: County of Residence: DOB:

Phone # (Home): Phone # (Work): Phone # (Cell):

City: State: Zip: Address, City, State Zip:

Phone Number: Parent / Guardian (if applicable): Relationship:

User: NICH 
Site: TEST

- Main
- Patient Registration
- Order Entry**
- Batch Build
- Batch Print
- Label Print
- Inquiry
- Reporting
- Pending
- Admin
- User Guide

Log Out



INSU User: NICH 
Site: TEST

- Main
- Patient Registration
- Order Entry**
- Batch Build
- Batch Print
- Label Print
- Inquiry
- Reporting
- Pending
- Admin
- User Guide

Log Out

**GEORGIA PUBLIC HEALTH
LABORATORY SUBMISSION FORM**

Complete a separate form for each test requested

HEALTH CARE PROVIDER INFORMATION **PATIENT INFORMATION**

Submitter Code: TEST: TEST SUBMIT COPYTO Code: Patient ID Number: Patient Number (LAB Unique ID):  

Submitter Name: TEST SUBMITTER PATIENT NAME (Last, First MI, Suffix):

Address: County of Residence: DOB:

Phone # (Home): Phone # (Work): Phone # (Cell):

City: State: Zip: Address, City, State Zip:

Phone Number: Parent / Guardian (if applicable): Relationship:

Field: D.O.B. Starts with: Contains:

Search: 01/01/2001 Get Data

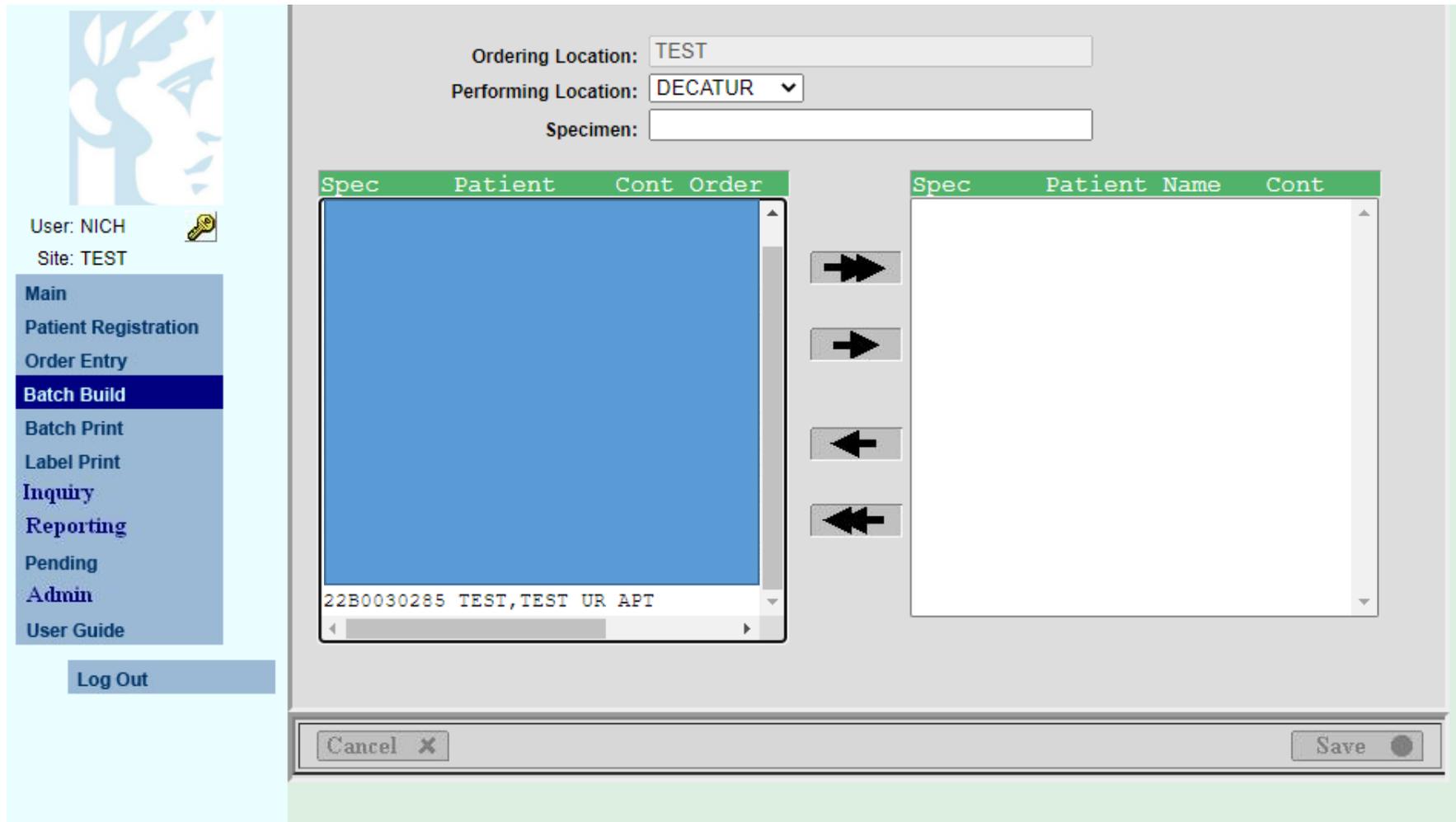
Last	First	D.O.B.	Phone #	Addr	Zip	Patient ID	Unique ID
TEST	TEST	01/01/2001				123456	2198353

If you want to enter in an additional test for a previous patient:

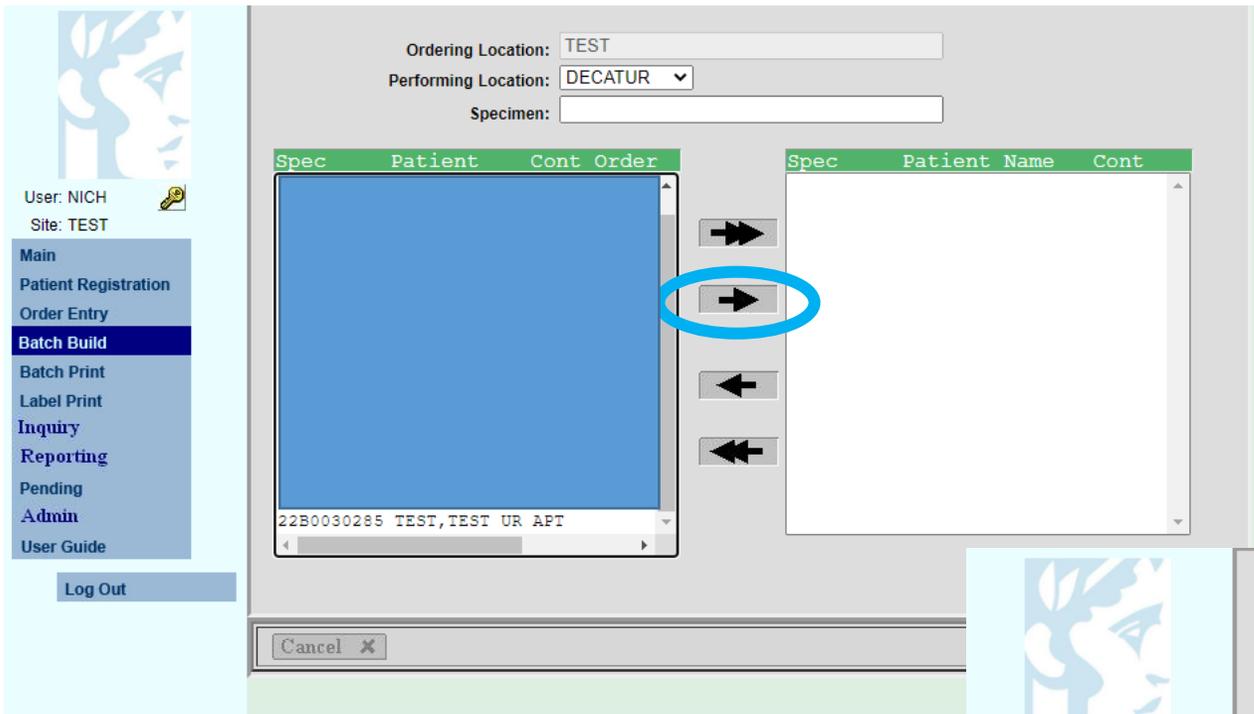
Click the **GREEN +** to obtain a new Lab #, and instead of clicking the pencil, **SELECT** the **magnifying glass**.

A window will pop-up, and you can search the patient's information by Last Name, First Name, DOB or Patient ID.

Once you have found your patient, click the **blue link** under **Unique ID** and the patient information will auto-populate into the submission form.



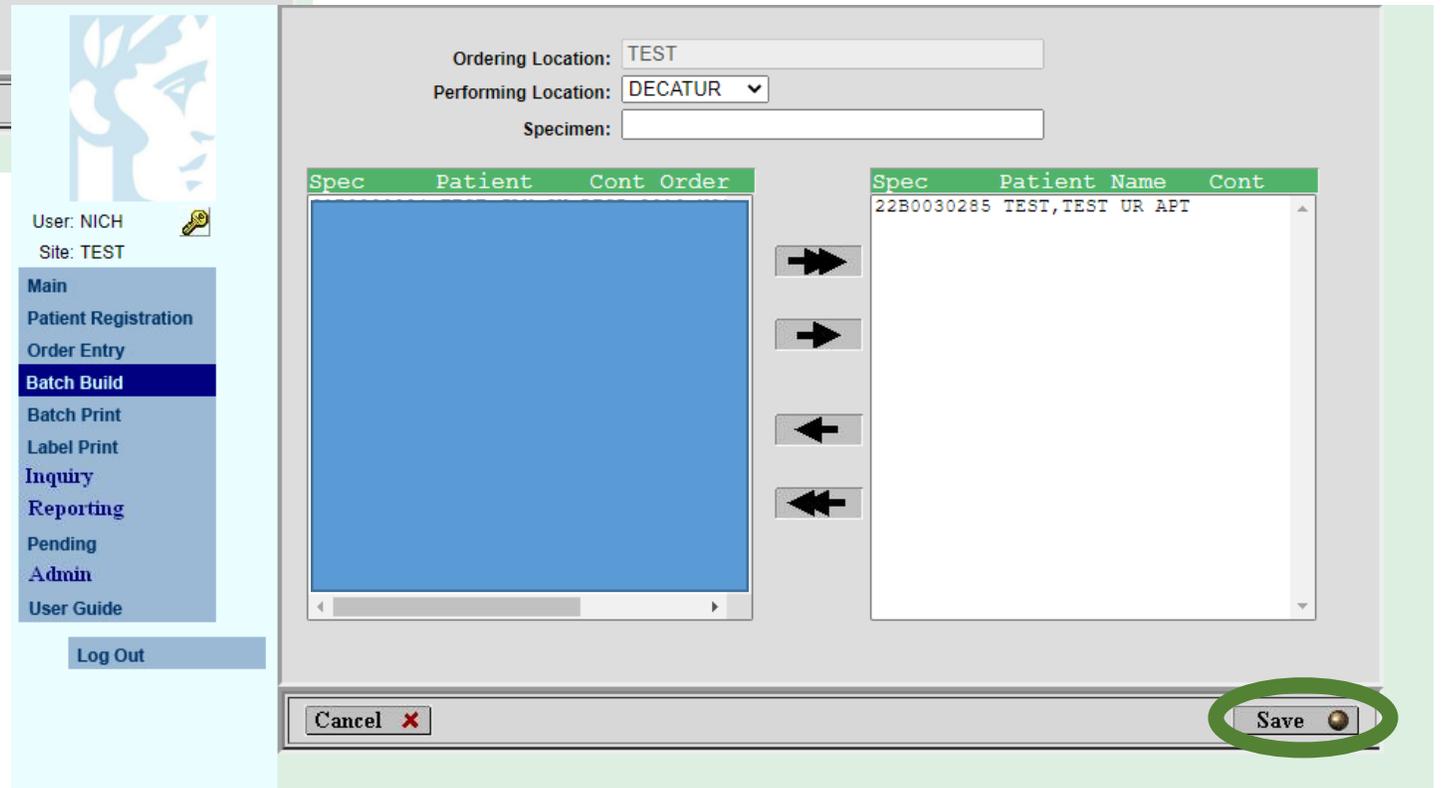
Once you have entered in all of your patients,
Select **BATCH BUILD** from the Menu on the left and the above screen will appear.



Click on the patient you want to put on the Batch List. It will be highlighted.

Once it is highlighted, click the **arrow pointing to the right** to move the patient to the Batch List.

Once you have selected all of your patients and moved them to the Batch List, click **SAVE**





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- Main
- Patient Registration
- Order Entry
- Batch Build**
- Batch Print
- Label Print
- Inquiry
- Reporting
- Pending
- Admin
- User Guide

Log Out

Ordering Location: TEST
Performing Location:
Specimen:

Spec	Patient	Cont	Order	Spec	Patient Name	Cont
05/11/2022, 15:39:08 Batch Shipment List: <input type="button" value="Print"/> <input type="button" value="Close"/>						
Ordering Location: TEST Performing Site: *MAIN Batch #:22051101						
Specimen #	Patient Name	Date of Birth	Coll Date	Container	Test(s)	
22B0030285	TEST, TEST	01/01/2001	05/11/2022	UR	APT	

Once you click SAVE,
your Batch list will pop up.

Click **PRINT**.

Your Print Box will appear. Be
sure to print 2 copies; 1 copy
for your records and 1 copy to
be sent with your specimens
to the Lab.

Put specimens in a BIOHAZARD BAG with absorbent material.
Ship to GPHL in a Category B Box on Ice.

Separate specimens by batch. Pack each batch together and include the Batch list in the package with the specimens. Do not mix batches when packing. Each Batch should be packed separately.