****

**GEORGIA PUBLIC HEALTH LABORATORY SUBMISSION FORM**

***(Not to be used for Newborn Screening Tests)***

Laboratory use only

***Complete a separate form for each test requested***

***Effective 7/1/2013***

Please Do Not Submit this form prior to 7/1/2013

|  |
| --- |
| **Choose Lab to Perform Test** |
| Decatur  Waycross |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***HEALTH CARE PROVIDER INFORMATION*** | | | | | | | | | | | | | | | | | | | | | ***PATIENT INFORMATION*** | | | | | | | | | | | | | | | | | | | | |
| **Submitter Code** | | | | | | | | | | | | | | | | | | | | | **Patient ID Number** | | | **PATIENT NAME (Last)** | | | | | | | | **First** | | | | | | | **MI** | | **Suffix** |
|  |  |  | |  | | |  |  | | | |  | | | |  | |  | | |  | | |  | | | | | | | |  | | | | | | |  | |  |
| **Submitter Name** | | | | | | | | | | | | | | | | | | | | | **County of Residence** | | | | | | | | | | | | | | **DOB** | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | \_\_\_/\_\_\_/\_\_\_\_\_\_ | | | | | | |
| **Street Address** | | | | | | | | | | | | | | | | | | | | | **Home Phone:** | | | | | **Work Phone:** | | | | | | | | | | **Cell Phone:** | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | | | | | | | | |  | | | | | |
| **City** | | | | | | | | | **State** | | | | | **Zip** | | | | | | | **Address** | | | | | | | | | | | | **City,** | | | | **State** | | | **Zip** | |
|  | | | | | | | | |  | | | | |  | | | | | | |  | | | | | | | | | | | |  | | | |  | | |  | |
| **Phone Number** | | | | | | | | | | | | | | | | | | | | | **Parent / Guardian (if applicable)** | | | | | | | | | | | | | **Relationship** | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |
| **Fax Number** | | | | | | | | | | | | | | | | | | | | | **RACE** | | | | | | | | | | **ETHNICITY** | | | | | | | **Sex** | | | |
|  | | | | | | | | | | | | | | | | | | | | | American Indian/Alaska Native  Asian  Black/African-American  Native Hawaiian/Pacific Islander  White/ Caucasian  Multi Racial | | | | | | | | | | Hispanic or Latino  Non-Hispanic or Latino | | | | | | | Male  Female | | | |
| **Contact Name** | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | **Pregnant?**  Yes No N/A | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | |
| **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*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ACCEPTED INSURANCE**  **FOR FUTURE USE**  Amerigroup  Peach State  Wellcare  Medicaid/  Peachcare | | | **ID Number** | | | | | | | | | | | | **Plan Name** | | | | | | | | **Group Number** | | | | | **Policy Holder’s Name (Last, First, M)** | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | |  | | | | | | | |  | | | | | , | | | | | | | | | | | | | |
|  | | | **Policy Holder’s DOB** | | | | | | | | | | **Policy Holder’s Mailing Address** | | | | | | | | | | | | | | | | | **Patient’s Relationship to Policy Holder** | | | | | | | | | | | |
|  | | | \_\_\_/\_\_\_/\_\_\_\_\_\_ | | | | | | | | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |
|  | | | **Insurance Phone #** | | | | | | | | | | **Insurance Mailing Address** | | | | | | | | | | | | | | | | | **Coverage Effective Date** | | | | | | | | | | | |
|  | | |  | | | | | | | | | |  | | | | | | | | | | | | | | | | | \_\_\_/\_\_\_/\_\_\_\_\_\_ | | | | | | | | | | | |
| **ICD 9 Diagnosis Codes**  **Required for insurance purposes only.** | | | | | | | | | | | **Sequence Code 1 Sequence Code 2 Sequence Code 3** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***SPECIMEN INFORMATION \*All tests are performed at the Decatur Laboratory unless specified.*\* *TEST REQUESTED*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Arthropod  Abscess  Blood  Body fluid  Bronchial Wash  CSF  Endocervical  Isolated Organism  Lesion/General Swab  Lesion/Genital Swab  Nasopharyngeal Aspirate  Nasopharyngeal Swab  Pinworm  Plasma  Rectal Swab  Serum (Acute/Convalescent)  Sputum  Stool/Feces  Throat/Pharynx  Tissue  Urethra  Urine  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | Date of Collection  \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_  Time of Collection  \_\_\_\_\_:\_\_\_\_\_ AM PM  **SHIPPED**  Frozen  Refrigerated  Room Temperature  Outbreak related  Yes  No  If yes, name of outbreak:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Travel  Yes  No  Where?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Symptoms  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | ***BLOOD LEAD***  ***(Waycross Only)***  **W4050 Waycross**    **COLLECTION METHOD**  Capillary  Venus | | | | | | | | ***CHEMICAL THREAT***  ***(Decatur only)***  **Consultation with GPHL Emergency Response Coordinator required.**  **24/7 contact number** 404-655-3695  866-782-4584    CT041100 Rapid Toxic Screen (RTS)  (Performed at the CDC)  CT021500 Cadmium, mercury and lead (blood)  CT021700 Toxic Elements Screen (TES) (urine)  (As, Ba, Be, Cd, Pb, Tl, U)  CT021600 Mercury (urine)  CT011100 Cyanide (blood)  CT011200 Volatile Organic Compounds (VOC)  (blood)  CT011300 Tetramine (urine)  CT031100 Organophosphate Nerve Agent  metabolites (OPNA) (urine)  CT031200 Metabolic Toxins Panel (MTP) (urine)  CT031300 Abrine and Ricinine (ABRC) (urine)  Hold for testing  Illness related to chemical exposure  Yes  No  Name/ID number of event \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |
|  | | | | | |  | | | | | | | | | | | | | | ***MOLECULAR BIOLOGY***  ***(Decatur only)***  **Consultation with district epidemiologist required.**  **BT agent rule out (RT-PCR)**  BTC01005 *Bacillus anthracis*  BTC02005 *Brucella spp.*  BTC03005 *B. mallei/pseudomallei*  BTC04005 *Francisella tularencis*  BTC06005 *Yersinia pestis*  BT99000 BT send out CDC  414000 **Bordetella pertussis (RT-PCR)**  400050 **Influenza panel (rRT-PCR)**  413000 **Mumps (RT-PCR)**  416000 **Measles (RT-PCR)**  1305 **Norovirus (rRT-PCR)**  BTC05000 **Rash Illness Panel (RT-PCR)**  421000 **VZV (RT-PCR)**  499100 **Refer to CDC**   \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |  | | | | | | | | | | | | | |
| **A correlating list of tests and prices is located at** [**http://health.state.ga.us**](http://health.state.ga.us) **Page 1of 2 - Form 3583 (Revised 6/28/13)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PATIENT NAME**  Last: | | | | | First: | | | | | | | | | | | | MI. | | | | | | | | **For Laboratory Use Only** | | | | | | | | | | | | | | | | |
| ***BACTERIOLOGY*** | | | | | | | | | | | | | | | | | | | | | | ***IMMUNOLOGY*** | | | | | | | | | | | | | | | | | | | |
| **Enteric isolates**  1100 Campylobacter  1070 STEC  1110 Salmonella  1080 Shigella  1160 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 **Gonorrhea Culture**  **Nucleic Acid Amplification Test (Chlamydia/Gonorrhea)**  **1060 Decatur**  **W1000 Waycross**  1135 **Forward to CDC1 (Please specify)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *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  Campylobacter  C. perfringens  Listeria  STEC / SLT  Salmonella  Shigella  S. aureus | | | | | | | | | | | | | | | | | | | | | | **Routine Syphilis**  Routine RPR ***(Choose nearest location)***  1610 Decatur  W2000 Waycross  1630 VDRL (spinal fluid)  1640 TPPA  **Special RPR testing request**  1615 Quantitative (Titer) and Confirmatory even if screening test (RPR) is  negative  No Confirmatory Test needed even if screening test (RPR) is positive    **Arbovirus/WNV panel**  1595 Arbo IgG panel  1600 Arbo IgM panel  1580 WNV lgG  1585 WNV lgM  1590 WNV lgM (CSF)  **Hepatitis Testing**  1411 Hep B (Prenatal)  1410 Hep B (Routine Screen)  1400 Anti-HAV Total Antibody  1405 Anti-HAV-IgM  1480 Anti-HCV  1490 HCV Viral Load  **Miscellaneous Serology**  1530 Toxoplasmosis IgG  1535 Toxoplasmosis IgM  1510 Rubella IgG  1515 Rubella IgM  1545 CMV IgG  1550 CMV IgM  1560 HSV1  1565 HSV2  1520 Rubeola IgG  1525 Rubeola IgM  1555 Mumps  1540 Varicella Zoster  14001 Torch Panel (CMV, HSV1, HSV2, Rubella, and Toxoplasmosis)    1570 Forward to **CDC**   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
| ***MYCOBACTERIOLOGY VIROLOGY RABIES*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Known TB Patient?**   Yes, current  Yes, former  No  **Clinical Specimens**  30100 Microscopic exam for AFB only  30000 Smear, culture & susceptibility testing  (Susceptibility Performed on MTB only)  30800 Nucleic Acid Amplification Testing (NAAT).  This test is intended for use only with specimens from newly infected patients showing signs and symptoms of active pulmonary tuberculosis.  **AFB Isolates**  34000 Identification  33950 Susceptibility testing (MTB only)  30750 Genotyping only | | | | | | | | | | | | | | | | | | | **HIV**  CTS#**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  13500 HIV Ag/Ab Combo  1360 HIV-1 Ab WB  1340 HIV-1 Viral Load  **VIRAL CULTURE**  62050 CMV Culture/IFA  62040 Measles Culture/IFA  60000 Mumps Culture/IFA  1385 Enterovirus Culture / IFA  1330 Herpes Culture / ELVIS  62000 VZV Culture / IFA  6100 Respiratory Culture / IFA  1375 Influenza Culture / IFA  Other \_\_\_\_\_\_\_\_\_\_\_\_\_/IFA  60040 Viral Culture / Identification  (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Gastrointestinal Outbreak Investigation**  60030 Rotavirus EIA  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | ***(Choose nearest location)***  1300 Decatur  W6000 Waycross  BITE NUMBER (EPI)  BI/A# **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Classification/Species of Animal**  Bat  Cat  Dog “Breed” **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Fox  Skunk  Raccoon  Other: **\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Pet  Wild  Stray  **COUNTY OF ANIMAL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Date killed **\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Reason for testing**  **(mandatory, check all that apply)**  Human exposure  Bite  Contact saliva  Scratch  Domestic animal exposure  Bite  Contact saliva  Scratch  Epidemiological Reasons  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |
| ***PARASITOLOGY*** | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | | |
| ***(Choose nearest location)***  **Cryptosporidium**  2400 Decatur  W5010 Waycross  **Cyclospora**   2500 Decatur  W5010 Waycross  **Formalin Fe**ces  2100 Decatur  W5000 Waycross  **PVA Feces**   2300 Decatur  W5020 Waycross  **Pinworm slide**   2200 Decatur  W5030 Waycross  2150 PCR  2710 Tissue/tissue smear for parasites  2700 Whole blood/blood smear for parasites - Malaria  2710 Whole blood/blood smear for parasites - Filaria  2800 Worm identification  2800 Miscellaneous identification  \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | | |

***All tests are performed at the Decatur Laboratory unless specified.***

**A correlating list of test and prices is located at** [**http://health.state.ga.us**](http://health.state.ga.us) **Page 2 of 2 – Form 3583 (Revised 6/28/13)**