

Date of Request _____ Requisition # _____

Ordering Provider: _____

Date of Birth _____ Gender _____

Attending Provider: _____

10/23, 12/25

Name Last: _____ First: _____

SPECIMEN		
COLLECTED BY:	TIME:	DATE:

Employee Health Facility _____

Please circle requests below.

Diagnosis Code:	
or	
Descriptive Diagnosis:	

**ENTER USING REQUISITION ENTRY USING APPROPRIATE SUBMITTER RECORD
BASED ON LOCATION EMPLOYED**

<p>Exposed Patient</p> <table style="width: 100%;"> <thead> <tr> <th style="text-align: left;">Code</th> <th style="text-align: left;">Test Name</th> </tr> </thead> <tbody> <tr> <td>LAB472</td> <td>Hep B Surface AB</td> </tr> <tr> <td>Lab21130</td> <td>Hep C AB</td> </tr> <tr> <td>LAB887</td> <td>Hep C RNA</td> </tr> <tr> <td>LAB473</td> <td>HIV Antibody/Antigen Combo Screen (Includes HIV-1/2 Antibodies and p24 Antigen)</td> </tr> </tbody> </table> <p>-Preliminary positive results will released -Positive results will reflex to confirmatory testing.</p> <table style="width: 100%;"> <tbody> <tr> <td>Lab131</td> <td>AST</td> </tr> <tr> <td>LAB132</td> <td>ALT</td> </tr> <tr> <td>LAB294</td> <td>CBC</td> </tr> <tr> <td>LAB66</td> <td>CRTN</td> </tr> <tr> <td>LAB50</td> <td>TBIL</td> </tr> </tbody> </table> <p>Other Testing: _____ _____ _____ _____ _____</p>	Code	Test Name	LAB472	Hep B Surface AB	Lab21130	Hep C AB	LAB887	Hep C RNA	LAB473	HIV Antibody/Antigen Combo Screen (Includes HIV-1/2 Antibodies and p24 Antigen)	Lab131	AST	LAB132	ALT	LAB294	CBC	LAB66	CRTN	LAB50	TBIL	<p>Source Patient</p> <table style="width: 100%;"> <thead> <tr> <th style="text-align: left;">Code</th> <th style="text-align: left;">Test Name</th> </tr> </thead> <tbody> <tr> <td>LAB471</td> <td>Hep B Surface AG</td> </tr> <tr> <td>LAB21130</td> <td>Hep C AB</td> </tr> <tr> <td>LAB473</td> <td>HIV Antibody/Antigen Combo Screen (Includes HIV-1/2 Antibodies and p24 Antigen)</td> </tr> </tbody> </table> <p>-Preliminary positive results will released -Positive results will reflex to confirmatory testing.</p> <p>If results need to be called please provide contact information below, if not results will be faxed to EMP health designated number. Please provide the person(s) to be contacted with the result. Such person(s) should be knowledgeable in the confidentiality requirements, and the fact that the result released will only be preliminary.</p> <p>Contact Person: Name: _____ Phone # _____ Pager# _____</p> <p>Additional Information: _____ _____ _____ _____</p>	Code	Test Name	LAB471	Hep B Surface AG	LAB21130	Hep C AB	LAB473	HIV Antibody/Antigen Combo Screen (Includes HIV-1/2 Antibodies and p24 Antigen)
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Provider's Signature: _____

Signed Date and Time: _____

Received by: _____

