CONFIDENTIAL REPORT: LABORATORY EVIDENCE OF CERTAIN COMMUNICABLE DISEASES
USE FOR REPORTING TO: MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE

USE FOR ALL COMMUNICABLE CONDITIONS EXCEPT HIV and CD4. (Use form DHMH 4492 for HIV and CD4.)

(PLEASE TYPE OR PRINT USING BLACK INK.)

PATIENT LAST NAME	FIRST	MIDDLE INITIAL	HOSPITAL NUMBER	PREGNANT? (FEMALE) YES ☐ NO ☐

DATE OF BIRTH	AGE	SEX	ETHNICITY HISPANIC ☐ NON-HISPANIC ☐	RACE

NUMBER	STREET	APT	CITY	STATE	ZIP	COUNTY	(AREA CODE) PHONE

ORDERING PROVIDER	NAME

NUMBER	STREET	SUITE	CITY	STATE	ZIP	COUNTY	(AREA CODE) PHONE (AREA CODE) FAX

ORDERING FACILITY NAME

NUMBER	STREET	SUITE	CITY	STATE	ZIP	COUNTY	(AREA CODE) PHONE

DATE SPECIMEN COLLECTED	DATE SPECIMEN RECEIVED	DATE RESULTED	LAB ACCESSION NUMBER

TYPE OF SPECIMEN

Sputum ☐ Stool ☐ Pharyngeal Swab ☐ Discharge ☐

Blood ☐ CSF ☐ Washing ☐ Other (Specify) _____

SITE OF SPECIMEN (CERVIX, EYE, ETC.)

NAME OF TEST	TEST NUMBER OR CODE

RESULT WITH REFERENCE RANGE & INTERPRETATION

(IF AN ORGANISM RESULT: INCLUDE SPECIES, SEROGROUPING, OR OTHER SUBTYPING IF KNOWN)

IF A HEPATITIS C RESULT:

Signal to Cut-Off Ratio (SCO)	Critical Value for SCO	Hepatitis A IgM Result	Hepatitis B Core IgM Result

LAB NAME (LAB PERFORMING THE TEST)	LAB CLIA NUMBER

LAB ADDRESS

LAB DIRECTOR	LAB (AREA CODE) PHONE	DATE OF REPORT

SEND TO YOUR LOCAL HEALTH DEPARTMENT

For more forms or information, go to http://www.edcp.org/html/reprtabl.html