

SPECIMEN SUBMISSION FORM
 WILLIAM A. HINTON STATE LABORATORY INSTITUTE
 305 SOUTH STREET, JAMAICA PLAIN, MA 02130-3597
 Phone 617-983-6200

**Do Not Use
This Space**

PRINT, APPLY LABEL OR STAMP: DO NOT ABBREVIATE

ONLY ONE TEST PER SUBMISSION FORM

Send Results To: Facility / Laboratory Name <i>(required)</i> Address Phone # Ordering Provider and Phone #	Patient Information: Last Name, First Name, MI Address Patient ID Phone # Sex: M F Other Date of Birth: Race: (Check One) <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <tr> <td style="width: 50%;"><input type="checkbox"/> American Indian or Alaska Native</td> <td style="width: 50%;"><input type="checkbox"/> Asian</td> </tr> <tr> <td><input type="checkbox"/> Black or African American</td> <td><input type="checkbox"/> White</td> </tr> <tr> <td><input type="checkbox"/> Native Hawaiian or Pacific Islander</td> <td><input type="checkbox"/> Other</td> </tr> </table> Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American	<input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Other
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian						
<input type="checkbox"/> Black or African American	<input type="checkbox"/> White						
<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Other						

Test Requested:

Collection Date:

Date of Onset:

_____ (required) One Per Form

_____ (required) One Per Form

_____ (required)

Serology			
<input type="checkbox"/> Acute	<input type="checkbox"/> Contact	<input type="checkbox"/> Test of Cure	
<input type="checkbox"/> Confirmation	<input type="checkbox"/> Surveillance		
<input type="checkbox"/> Convalescent	<input type="checkbox"/> Symptomatic		

Culture
Date of Culture: _____
Date of Subculture: _____
Sample Treated Y N If yes, how: _____

Source of Specimen: (required) One Per Form

<input type="checkbox"/> Anal canal	<input type="checkbox"/> Nasopharynx	<input type="checkbox"/> Stool	<input type="checkbox"/> Body Fluid (site)
<input type="checkbox"/> Blood	<input type="checkbox"/> Plasma	<input type="checkbox"/> Throat (pharynx)	<input type="checkbox"/> Bronchus (site)
<input type="checkbox"/> Bone Marrow	<input type="checkbox"/> Serum	<input type="checkbox"/> Urethra	<input type="checkbox"/> Exudates (site)
<input type="checkbox"/> Cervix	<input type="checkbox"/> Spinal Fluid	<input type="checkbox"/> Urine	<input type="checkbox"/> Wound (site)
<input type="checkbox"/> Gastric	<input type="checkbox"/> Sputum		<input type="checkbox"/> Tissue (site)
<input type="checkbox"/> Other: (Specify) _____			

Additional Patient Information:

Symptoms, and Duration
Travel History (Dates and Locations)
Animal / Insect contact: (specify)
Relevant Immunizations (Dates)
Previous Laboratory Results

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Please fill out “Additional Patient Information” section on front of form for the following tests:

Adenovirus	Herpes	Rickettsia
Arbovirus testing	Influenza	Respiratory Syncytial virus (RSV)
Babesia	Lymphocytic choriomeningitis virus (LCM)	Rubella
Campylobacter	Legionella	Salmonella
Chikungunya	Lyme Disease	Shigella
Cytomegalovirus (CMV)	Measles	St. Louis Encephalitis
Dengue Fever	Mumps	Syphilis
E. coli	<i>Mycoplasma pneumoniae</i>	Vaccinia virus
Eastern Equine Encephalitis	Parainfluenza	Varicella zoster
Enterovirus	Parasitology serology	Vibrio
Ehrlichia	Pertussis	West Nile Virus
Hantavirus	Q Fever	Yellow Fever