



Oklahoma State Department of Health  
 Public Health Laboratory  
 P.O. Box 24106  
 Oklahoma City, Oklahoma 73124

Patient Information	Submitter Information
<b>Patient ID/Scan:</b> <input type="text"/>	<b>Submitter ID:</b> <input type="text"/>
<b>Name:</b> <input type="text"/>	<b>Name:</b> <input type="text"/>
<b>Address:</b> <input type="text"/>	<b>Org:</b> <input type="text"/>
<b>City:</b> <input type="text"/> <b>State:</b> <input type="text"/>	<b>Address:</b> <input type="text"/>
<b>County:</b> <input type="text"/> <b>Zip:</b> <input type="text"/>	<b>CSZ:</b> <input type="text"/>
<b>DOB:</b> <input type="text"/> <b>Sex:</b> <input type="text"/>	<b>County:</b> <input type="text"/> <b>PGM:</b> <input type="text"/>
<b>Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian/ Native Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/ Pacific Islander <input type="checkbox"/> Other	<b>Phone No. (ac):</b> <input type="text"/>
<b>Ethnicity:</b> <input type="radio"/> Hispanic <input type="radio"/> Unknown <input type="radio"/> Non-Hispanic	<b>Clinical Information</b>
	<b>Date of Collection:</b> <input type="text"/> <b>Onset:</b> <input type="text"/>
	<b>Time of Collection:</b> <input type="text"/> (HH:MM) <input type="radio"/> AM <input type="radio"/> PM
	<b>Physician:</b> <input type="text"/>
	<b>Physician Phone (ac):</b> <input type="text"/>
	<b>Antibiotics:</b> <input type="text"/>

**PLEASE SELECT TEST REQUESTED**

Serology Testing	Specimen/Source	Microbiology Testing
<input type="checkbox"/> Blood Banking (whole blood only) <small>CHD Maternity Patients Only</small> <input type="checkbox"/> Syphilis Test <input type="checkbox"/> Premarital Previous Result/Titer: <input type="text"/>	<input type="radio"/> Blood <input type="radio"/> Bronchial Washing <input type="radio"/> Cervix <input type="radio"/> CSF <input type="radio"/> Dry Blood Spot <input type="radio"/> Eye <input type="radio"/> Nasopharyngeal <input type="radio"/> Oral Fluid <input type="radio"/> Plasma <input type="radio"/> Serum <input type="radio"/> Skin <input type="radio"/> Sputum <input type="radio"/> Sputum Nebulized <input type="radio"/> Stool <input type="radio"/> Throat <input type="radio"/> Urethra <input type="radio"/> Urine <input type="radio"/> Vaginal <input type="radio"/> Wound <input type="radio"/> Other: <input type="text"/>	<input type="radio"/> Enteric Bacteriology Suspected Agent: <input type="text"/> <input type="checkbox"/> Isolation & Identification <input type="checkbox"/> Confirmation <input type="checkbox"/> Serotyping <input type="radio"/> Referred Culture Suspected Agent: <input type="text"/> <input type="radio"/> Aerobic <input type="radio"/> Anaerobic <input type="radio"/> Pertussis <input type="radio"/> Parasitology <input type="radio"/> Group B Strep Screen
<b>Immunology</b>		<b>Mycobacteriology</b>
<input type="checkbox"/> Arboviral Panel (WN and SLE) <input type="checkbox"/> HIV-1 Antibody (red stoppered tube) <input type="checkbox"/> Rubella Screen (Maternity Patients Only) <input type="checkbox"/> Tick Panel		<input type="radio"/> Isolation & Identification <input type="checkbox"/> Fungal Testing <input type="checkbox"/> NAA <input type="radio"/> Other: <input type="text"/>
<b>Hepatitis</b>		<b>Laboratory Use Only</b>
<input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B Surface Antigen <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Other		
<b>Virology</b>	<b>Environmental Sample</b>	
<input type="checkbox"/> Neisseria gonorrhoeae/ Chlamydia trachomatis <input type="checkbox"/> Virus Isolation & Identification <input type="checkbox"/> Virus Identification Disease Suspected: <input type="text"/>	Source: <input type="text"/>	