

1. Last Name	First Name	MI
2. Patient Number (Soc. Security No.)		- H
3. Address	4. Date of Birth	
Zip Code	Month	Day Year
5. Race <input type="checkbox"/> 1. White <input type="checkbox"/> 2. Black <input type="checkbox"/> 3. American Indian <input type="checkbox"/> 4. Asian <input type="checkbox"/> 5. Native Hawaiian/Pacific Islander <input type="checkbox"/> 6. Unknown		
6. Hispanic or Latino Origin: <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 3. Unknown		
7. Sex <input type="checkbox"/> 1. Male <input type="checkbox"/> 2. Female	8. Co. of Residence	
9. Medicaid Client <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, enter #		

DO NOT WRITE IN THIS SPACE

LABORATORY NUMBER

North Carolina  
Department of Health and Human Services  
**State Laboratory of Public Health**  
Leslie Wolf, PhD, Director  
Microbiology Branch  
306 N. Wilmington St. • P.O. Box 28047  
Raleigh, NC 27611-8047  
(919) 733-7367  
Fax: (919) 733-8695

DATE RECEIVED

**PLEASE GIVE ALL INFORMATION REQUESTED**

SPECIMEN TYPE:

- CLINICAL SPECIMEN  
 ISOLATED ORGANISM\*

\* Describe \_\_\_\_\_

DATE SPECIMEN COLLECTED

M	D	Y
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EXAMINE FOR:

- MOLD  
 YEAST

SPECIMEN SOURCE:

- SPUTUM  URINE  BRONCHIAL  
 OTHER (*specify*) \_\_\_\_\_

TRAVEL INFORMATION:

Federal Tax No.: \_\_\_\_\_

Send Report To: \_\_\_\_\_

**MYCOLOGY (Fungus)**

DHHS 2010 (Revised 10/08)  
Laboratory (Review 10/10)

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## INSTRUCTIONS

PURPOSE: Isolation, identification, confirmation, further studies of human disease-producing yeasts or mold.

PREPARATION: Collect specimen by following instructions in SCOPE. Label each specimen tube or subculture with patient's name and your laboratory number if appropriate. Fill out this form and send in appropriate mailer with the specimen to State Laboratory of Public Health. Place form in **outer** container. Do not send without label (patient's name) on specimen or without form. Forms must be printed from our Web site at <http://slph.ncpublichealth.com>.

PREPARATION OF FORM: *Left Upper Portion of Form.* Item 1. Enter patient's name, last name first, first name, and middle initial or maiden name initial, if female. Item 2. Enter patient's social security number. ***This is the identifying number for that patient.*** If the patient has no social security number, please indicate on form. Item 3. Enter patient's **home** address on lines immediately below. This information is required for epidemiologic follow-up. Item 4. Enter date of birth (not age). Items 5, 6, and 7. Indicate race, Hispanic Ethnicity, and sex by checking appropriate box. These data are for statistical purposes only. Item 8. Enter county of residence of patient (use county code). Item 9. Indicate if patient is a Medicaid client; if yes, enter Medicaid number. Item 10. Indicate if patient is a Family Planning or EPSDT client by checking box. Enter submitter federal tax number or social security number in blank. Also enter return address of submitter in box under "Send Report To:".

*Right Upper Portion of Form.* Specimen Type: Check appropriate box. Date Collected: Enter date as indicated. Specimen Source: Check appropriate box. Examine For: Suspected disease or type examination required. Travel Information: Give travel (foreign or domestic) in last 5 years.

DISPOSITION: This form may be destroyed in accordance with Standard 5, Patient Clinical Records, of the *Records Disposition Schedule* published by the N.C. Division of Archives and History.

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