PARASITOLOGY

N.C. Department of Health and Human Services
State Laboratory of Public Health
4312 District Drive ● P.O. Box 28047
Raleigh, NC 27611-8047

Please Give All Information Requested *Attach Printed Label Below*

Patient Information

Last Name

First Name | MI

Maiden Name/Surname

Address/Attention:

Street Address: | Address 2: | City:

State: | Zip Code: | County Code: | County Name: | Phone Number:

SSN: __ __ __/__ __/__ __ __ __ | Medicaid Number (if applicable): __ __ __ __ __ __ __ __ __ __

Medical Record Number: | Date of Birth: __ __/__ __/__ __ __ __

Sex:
- ❑ Male
- ❑ Female
- ❑ Unknown
- ❑ Ambiguous
- ❑ Transgender M2F
- ❑ Transgender F2M
- ❑ Transgender Unknown

Race (mark all that apply):
- ❑ White
- ❑ Black
- ❑ Asian
- ❑ Unknown
- ❑ American Indian/ Alaska Native
- ❑ Native Hawaiian/ Pacific Isles

Ethnicity:
- ❑ Hispanic or Latino Origin
- ❑ Non-Hispanic
- ❑ Unknown

Submitter

EIN: ___ ___ ___ ___ ___ ___ ___ ___ ___ - ___ ___ | Submitter Name:

Address: | Address 2: | City:

State: | Zip Code: | County Name:

Phone Number: | Email Address: | Fax Number:

Ordering Provider NPI: | Ordering Provider First and Last Name:

Specimen

Collection Date: __ __/__ __/__ __ __ __ | Reason for Testing (ICD-10 Dx Code): __ __ __ __ __ __ __

Specimen Source:
- ❑ Stool
- ❑ Other (specify) _____

Symptoms:

Test Ordered:

- ❑ **Intestinal Parasites Exam**
- ❑ **Cryptosporidium/Giardia**
- ❑ **Other** _____

Laboratory Number:

Do Not Write in this Space

Other

Fill in if applicable:

If traveled outside U.S. within last five years, where? _____

If Refugee, indicate nationality: _____

Migrant? ❑ Yes ❑ No