Lab Use Only

☐ **Acceptance Criteria Not Met**
- ☐ Inappropriate temperature
- ☐ Specimen too old
- ☐ Incomplete labeling/form
- ☐ Specimen inappropriate/damaged

Date: ___/___/_____ Initials:_____

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: ___/___/_____ Collection Time: ___:___ 24 Hr Time | 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