# SYPHILIS SEROLOGY

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

**Lab Use Only**

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

Date: ____/____/_____ Initials:_______

*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: ____/____/__________

If Female, Pregnant? ❑ Yes ❑ No ❑ Unknown

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

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

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

Clinic/Program Type:
❑ Prenatal ❑ STD ❑ Family Planning ❑ Outreach ❑ Student Health Services
❑ Jail/Detention Centers ❑ Other (specify): ______________________________

## 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

Collector's Initials:

Specimen source: Serum

Reason for Testing (ICD-10 Dx Code): __ __ __ __ __ __ __

Test ordered:

❑ **RPR (Titer and Confirmatory if Reactive)**

❑ ***Treponema pallidum* confirmatory serology**

**Specimen previously tested?** ❑ Yes ❑ No ❑ Unknown

**RPR/TRUST result** ______________________________

Laboratory Number:

*Do Not Write in this Space*

## Other

Please mark Reason for Testing:
❑ Routine screening ❑ Contact to a known case ❑ Past history of syphilis
❑ Prenatal ❑ Suspicious lesion ❑ Treatment follow-up
❑ Neonatal screening ❑ Secondary symptoms/signs ❑ Other ______________________________