[1] 1. **Last Name** | **First Name** | **MI**

2. **Patient Number**

3. **Address**

Zip Code

4. **Date of Birth** — Month / Day / Year

5. **Race** ☐ 1. White ☐ 2. Black ☐ 3. American Indian ☐ 4. Asian ☐ 5. Native Hawaiian/Pacific Islander ☐ 6. Unknown

6. **Hispanic or Latino Origin?** ☐ 1. Yes ☐ 2. No ☐ 3. Unknown

7. **Sex** ☐ 1. Male ☐ 2. Female

8. **Co. of Residence**

9. **Medicaid Client** ☐ Yes ☐ No
If yes, enter #

DO NOT WRITE IN THIS SPACE
LABORATORY NUMBER

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

HEPATITIS SEROLOGY

[2] Federal Tax No.: ______________________

Send Report To:

____

____

______________________ Zip Code: __________

[3] Date Collected:

[4] Date of Onset:

[5] Site ID No.:

[6] Dx Code/ICD-10:

[7] Ordering Provider Name: ______________________

Provider NPI:

[8] Test Panel(s) Requested:

☐ **Hepatitis B Virus (HBV) Screen**

Reason for testing (Must check all that apply to your patient):

☐ Prenatal patient
Estimated Date of Confinement (EDC) ____/____/____

☐ Refugee

☐ Sexual or needlesharing contact of known infected person

☐ Household contact of chronic HBV carrier (or acute cases) who is at high risk of HBV exposure and who is a candidate for HBV vaccine

☐ Other, explain (prior approval required)*

____

____

☐ Source patient from whom exposure occurred

☐ **Hepatitis B Virus (HBV) Monitor**

Reason for testing (Must check all that apply to your patient):

☐ Follow-up of infant (12-15 months old) born to infected mother

☐ Follow-up of person with previous positive test for HBsAg or history of Hepatitis B infection

☐ Previously vaccinated health department employee with percutaneous exposure to Hepatitis B

☐ **Hepatitis Diagnostic**

Reason for testing (Must check all that apply to your patient):

Hepatitis B Virus (HBV)

☐ Symptomatic (recent or current)

Hepatitis A Virus (HAV)

☐ Symptomatic without an epidemiologic link to another case known to be infected with Hepatitis A

☐ Confirmation of suspected cases, whether or not epidemiologically-linked, if: *(please indicate)*

- ☐ foodhandler
- ☐ health care worker
- ☐ daycare attendee
- ☐ daycare worker
- ☐ at risk for other causes of liver disease (i.e., reports IV drug use, alcohol abuse, other)

☐ **Hepatitis A Virus (HAV) Outbreak**

Reason for testing (Must check all that apply to your patient):

☐ Outbreak situation *(prior approval required)**

☐ Other, explain *(prior approval required)**

____

____

____

____

____

FOR LABORATORY USE ONLY

Unsatisfactory Specimen:

☐ No name on specimen
☐ Name on specimen/form do not match
☐ Specimen broken/leaked
☐ No specimen received
☐ Other ______________________

*SEE REVERSE SIDE FOR INSTRUCTIONS AND FURTHER INFORMATION

INSTRUCTIONS

PURPOSE: Submission of specimens for Hepatitis B and Hepatitis A testing.

PREPARATION: Submit at least 2 mL of serum in a plastic screw-capped vial. Clearly label each specimen with the patient's first and last name, and either date of birth, patient number or other unique identifier. Specimens without names or incorrectly labeled specimens will be deemed unsatisfactory for testing. For additional information, see "SCOPE, A Guide to Services" on our website at http://slph.ncpublichealth.com or contact the Virology/Serology Unit at (919) 733-7544.

PREPARATION OF FORM: Please print legibly or use a preprinted label. To avoid delays in testing, fill out all items in Sections 1 through 8 of the submission form. The information in Section 8 will be used to determine which hepatitis markers will be tested and the eligibility of the specimen for testing (see "HEPATITIS TESTING PANELS AND CORRESPONDING MARKERS" below). Prior arrangements are required before submitting specimens for Hepatitis A outbreaks and other situations addressed in Section 8. To make arrangements, call (919) 733-7544; indicate on request form that such arrangements were made.

SHIPMENT: Send properly identified specimen and completed submission form to the Laboratory as soon as possible. Additional serum transport tubes and buff-label specimen mailers for Hepatitis Serology are available through the NCSLPH online supply ordering system on our website at http://slph.ncpublichealth.com.

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.

HEPATITIS TESTING PANELS AND CORRESPONDING MARKERS

PANEL	POPULATION	MARKER				
		HBsAg[1]	Anti-HBc[2] IgM	Anti-HBs[3]	Anti-HBc[4] Total	Anti-HAV[5] IgM
Hepatitis Diagnostic	Symptomatic	X	X			X
Hepatitis B Screen	Prenatal	X	X if HBsAg (+)			
	Refugee	X	X if HBsAG (+)		X	
	Sexual or needlesharing contact of known infected person <u>OR</u> Household contact of chronic HBV carrier or acute cases	X	X if HBsAg (+)	X if HBsAg (-)		
	Source patient from whom exposure occurred	X	X if HBsAg (+)			
Hepatitis B Monitor	Follow-up of infant (12-15 months) born to infected mother	X		X		
	Follow-up of person with previous positive test for HBsAg or history of HBV infection	X		X	X	
	Previously vaccinated health department employee with percutaneous exposure to HBV			X		
Hepatitis A Outbreak						X

[1]HBsAG Hepatitis B Surface Antigen (Australia Antigen)
[2]Anti-HBcIgM IgM Antibody to Hepatitis B Core Antigen
[3]Anti-HBs Antibody to Hepatitis B Surface Antigen
[4]Anti-HBc Antibody to Hepatitis B Core Antigen
[5]Anti-HAVIgM IgM Antibody to Hepatitis A Virus