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
Raleigh, NC 27607

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:
Insurance ID Number: (if applicable) _____			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

For more information, refer to website at https://slph.dph.ncdhhs.gov/