Lab Use Only

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

Date: ___/___/____ Initials:_____

SYPHILIS SEROLOGY

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: ___/___/_____ | If Female, Pregnant? ☐Yes ☐No ☐Unknown

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

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
- ☐ Prenatal
- ☐ Neonatal screening
- ☐ Contact to a known case
- ☐ Suspicious lesion
- ☐ Secondary symptoms/signs
- ☐ Past history of syphilis
- ☐ Treatment follow-up
- ☐ Other _____