### Test Combination / Panel Policy

Barnes-Jewish Hospital Department of Laboratories (Back)

In an effort to keep our clients fully informed of the content, charges, and coding of all test combinations/panels when billed to Medicare, we periodically send notices concerning test combinations/panels, as well as information regarding patient fees, to all services. We also welcome the opportunity to provide, on request, additional information in connection with our testing services and the manner in which they are billed to physicians, health care plans, and patients.

The CPT codes listed here are in accordance with the 2019 edition of Physicians' Current Procedural Terminology, a publication of the American Medical Association. CPT codes are provided here for the convenience of our clients; however, correct coding often varies from one carrier to another. Consequently, the codes presented here are intended as general guidelines and should not be used without confirming with the appropriate payer that their use is appropriate in each case. All laboratory procedures will be billed to third-party carriers (including Medicare and Medicaid) at fees billed to patients and in accordance with the specific CPT coding required by the intermediary. CPT codes 80020-80019, previously used for automated multichannel testing, have been eliminated as of January 1, 1999. New organ or disease panel CPT codes will be used instead, as noted below. Microbiology CPT code(s) for additional procedures such as susceptibility testing, identification, serotyping, etc., will be billed in addition to the primary codes when appropriate.

### Organ/Disease Oriented Panels

<table>
<thead>
<tr>
<th>Organ or Disease Oriented Panels</th>
<th>Basic Metabolic Panel</th>
<th>OBSTETRIC PANEL</th>
<th>Hepatic Function Panel</th>
</tr>
</thead>
<tbody>
<tr>
<td>80041</td>
<td>Carbon Dioxide</td>
<td>Complete Blood Count</td>
<td>Albumin</td>
</tr>
<tr>
<td></td>
<td>Chloride</td>
<td>Hepatitis B surface antigen (HBsAg)</td>
<td>Bilirubin, Total</td>
</tr>
<tr>
<td></td>
<td>Creatinine</td>
<td>Rubella Antibody IgG</td>
<td>Alkaline Phosphatase</td>
</tr>
<tr>
<td></td>
<td>Potassium</td>
<td>RPR</td>
<td>AST (SGOT)</td>
</tr>
<tr>
<td></td>
<td>Sodium</td>
<td>Type and Screen</td>
<td>ALT (SGPT)</td>
</tr>
<tr>
<td></td>
<td>Urea Nitrogen</td>
<td></td>
<td>Bilirubin Direct</td>
</tr>
<tr>
<td></td>
<td>Glucose</td>
<td></td>
<td>Protein Total</td>
</tr>
<tr>
<td></td>
<td>Calcium</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lipid Panel</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cholesterol Total</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Triglycerides</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>80051</td>
<td>Electrolyte Panel</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Carbon Dioxide</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chloride</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Potassium</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sodium</td>
<td></td>
<td></td>
</tr>
<tr>
<td>80053</td>
<td>Comprehensive Metabolic Panel</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Albumin</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bilirubin, Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Calcium</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Carbon Dioxide</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chloride</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Creatinine</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Potassium</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urea Nitrogen</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alkaline Phosphatase</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Potassium</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sodium</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>AST (SGOT)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urea Nitrogen</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Glucose</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ALT (SGPT)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Acute Hepatitis Panel</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hepatitis A AB IG</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hepatitis B Core AB IG</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hepatitis B Surface AG</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hepatitis C AB</td>
<td></td>
</tr>
</tbody>
</table>

### Additional CPT Codes

- O & P Exam Screen: Cryptosporidium Antigen - 87528
- Giardia Antigen - 87532
- Neutrophil OAP Complete Microscopic If Comprehensive Exam is Needed

### OrganFunctions in Tumor Marker

- Thyroglobulin - 84432
- Thyroglobulin Ab Screen - 88890

### Thyroid Function Cascade

- TSH - 84443
- FREE T4 (if appropriate) - 84439

### Type and Screen

- ABO Typing - 86900
- Antibody Screen - 86950
- Rh Typing - 86901

### Indications

- Refer to Laboratory Test Catalog
Cytology Laboratory Requisition

Cytology GYN (PAP SMear)

- Source (✔️ That Apply)
  - Uterine
  - Cervical
  - Endocervical
  - EC Brush
  - Endometrial
  - Other
  - Individual

- Menstrual Status: LMP (REQUIRED)
  - Regular
  - Irregular
  - Pregnant
  - Post Partum
  - Lactating

- Contraceptive Use?
  - No
  - Yes

- Other Hormonal Therapy?
  - No
  - Yes

- Prior abnormal cytology? *
  - No
  - Yes

- Prior treatment? *
  - No
  - Yes

- Other clinical conditions?
  - No
  - Yes

- Cytology: Other Sources

  - Respiratory
    - Sputum
    - Sputum, Post Bronch.
    - Bronchial Wash
    - Bronchial Brush
    - BAL
  
  - Urine
    - Bladder (void)
    - Bladder (Cath)
    - Ureter
    - Renal Pelvis
    - Fish Bladder CA
  
  - Fluids
    - Pericardial Fluid
    - Peritoneal Fluid
    - Pleural Fluid
    - Cerebrospinal Fluid
    - Pelvic Washing

- Cytology: Other Sources

  - Gastric
    - Brushing
    - Washing
  
  - Esophageal
    - Brushing
    - Washing
  
  - Fine Needle Aspiration
    - Site:

- CLIA 200436872

Clinical Diagnosis and History:

Cytology #
Surgical Pathology Tissue Exam Request

**CLINICAL HISTORY AND DIAGNOSIS:**
Patient has metastatic disease?  □ Yes  □ No  □ Unknown  □ Not Relevant

**OB/GYN:**
Last Menses:  Date Ovulation:  G:  P:  AB:  Hormone RX:

**OPERATIVE PROCEDURE AND FINDINGS:**

□ RUSH (Biopsy only – Must be received prior to 11:00 am Monday-Friday for same day processing)

**SPECIMEN:** (SPECIFY SITE)
Number of specimens submitted (jars):
List specimens here (including SITE of Biopsy):

...
Prenatal Testing Requisition

### Account Information
- **NAME:**
- **ADDRESS:**
- **CITY:**
- **STATE:**
- **ZIP:**
- **PHONE:**
- **ORDERING PHYSICIAN'S SIGNATURE & UPIN:**
- **DUPLICATE REPORT TO:**
- **BILL TO:**
  - ACCOUNT
  - PATIENT/INSURANCE
  - RESEARCH
- **ACCOUNT NAME:**
  - PATIENT ACCT
  - RESEARCH ACCT
- **INSURANCE COMPANY NAME:**
  - MEMBER ID
  - GROUP #
- **INSURANCE ADDRESS:**
- **CITY:**
- **STATE:**
- **ZIP:**
- **EMPLOYER NAME/EMPLOYER #:**
  - INSURED SSN (IF NOT PATIENT)
- **CARE PARTNERS**
- **HEALTH PARTNERS**
- **OTHER (COMPLETE BELOW)**

### Patient Information
- **SSN:**
- **PHONE:**
- **PATIENT NAME: LAST, FIRST, MIDDLE:**
- **DATE OF BIRTH:**
- **SEX:**
  - M
  - F
- **SAMPLE TYPE:**
  - Serum
  - Fluid
- **SAMPLE DRAW DATE:**
- **REFERRING DOCTOR:**
- **TIME:**
  - AM
  - PM
- **HIC REGISTRATION #:**
- **ACCESSION NUMBER:**
- **DIAGNOSIS:**
- **REFERENCE NO.:**

### Check Test(s) Requested
- **SERUM AFP STUDIES** (complete part A)
  - **AFP PROFILE FOUR** (AFP, Estriol, HCG, Inhibin)
  - **AFP ONLY** - for Neural Tube Defect screening only
- **SST FOR BLOOD STUDIES**

### Part A
- **LMP date:** __/__/____
- **U/S date:** __/__/____
- **GA on U/S date:** _______ wks. _______ days
- **Is this test a repeat?**
  - Y
  - N
- **Height:**
- **Current weight (lbs.):**
- **Pregnancy History:**
  - Vaginal bleeding this pregnancy? Y
  - N
- **Cigarette smoker?**
  - Y
  - N
  - If yes, how many per day?____
- **Has the patient had...**
  - Amniocentesis? or
  - CVS? date __/__/____
  - First trimester test for Down syndrome? date __/__/____

### Part B
- **REASON FOR AMNIOCENTESIS**
  - Elevated serum AFP
  - Abnormal U/S (explain)
  - Screen positive for DS
  - History of NTD
  - History of chromosome disorders
  - Advanced maternal age
  - Other (specify)
- **LMP date:** __/__/____
- **If U/S, _______ wks GA on date:** __/__/____
- **This specimen is:**
  - supernatant
  - whole fluid
  - Is it blood stained? Y
  - N

### Reference
- **FBR FOUNDATION FOR BLOOD RESEARCH**
- **Shipping Address:**
  - 9 Science Park Road
  - Scarborough, ME 04074
- **Tel:** (207) 883-4131
  - 1-800-639-6605
- **Fax:** (207) 883-1527
  - www.fbr.org
**Molecular Diagnostic Laboratory Request for DNA Studies-Medical Genetics**

**ACCOUNT INFORMATION**

<table>
<thead>
<tr>
<th>COLLECTION INFORMATION</th>
<th>[ ] AM [ ] PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE</td>
<td>TIME</td>
</tr>
</tbody>
</table>

**ACCOUNT INFORMATION**

<table>
<thead>
<tr>
<th>NAME</th>
<th>ADDRESS</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
</tr>
</thead>
</table>

**ACCOUNT INFORMATION**

<table>
<thead>
<tr>
<th>PHONE</th>
<th>FAX</th>
</tr>
</thead>
</table>

**ACCOUNT INFORMATION**

<table>
<thead>
<tr>
<th>ORDERING PHYSICIAN</th>
<th>[ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID</td>
<td>REFERENCE NO.</td>
</tr>
</tbody>
</table>

**ACCOUNT INFORMATION**

<table>
<thead>
<tr>
<th>ACCOUNT</th>
<th>PATIENT ACCT</th>
<th>RESEARCH ACCT</th>
</tr>
</thead>
</table>

**ACCOUNT INFORMATION**

<table>
<thead>
<tr>
<th>MEDICARE</th>
<th>MEDICAID</th>
<th>CPT PARTNERS</th>
<th>HMO PARTNERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>D#</td>
<td>ALTA-Code</td>
<td>CHIP</td>
<td>OTHER</td>
</tr>
</tbody>
</table>

**ACCOUNT INFORMATION**

<table>
<thead>
<tr>
<th>INSURANCE CO.</th>
<th>ID #</th>
<th>ADDRESS</th>
<th>GRP #</th>
</tr>
</thead>
</table>

**ACCOUNT INFORMATION**

<table>
<thead>
<tr>
<th>INSURED NAME</th>
<th>(IF NOT PATIENT)</th>
<th>[ ]</th>
</tr>
</thead>
</table>

**NOT TO PHYSICIAN:** When seeking payment from Medicare or Medicaid, Physicians should only order tests that are medically necessary for the diagnosis or treatment of the patient, for instance, Medicare does not cover routine screening, testing that is “investigative” or research use only, testing with quantity limits.

**LABORATORY USE ONLY:**

<table>
<thead>
<tr>
<th>SPECIMEN CONDITION</th>
<th>TUBE TYPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specimen Number</td>
<td>EDTA</td>
</tr>
</tbody>
</table>

**LABORATORY USE ONLY:**

<table>
<thead>
<tr>
<th>Date Received</th>
<th>Time Received</th>
</tr>
</thead>
</table>

**For Children:**

<table>
<thead>
<tr>
<th>Father’s Name</th>
<th>City:</th>
<th>Zip Code:</th>
<th>State:</th>
</tr>
</thead>
</table>

**For Children:**

<table>
<thead>
<tr>
<th>Mother’s Name</th>
<th>State:</th>
<th>Zip Code:</th>
</tr>
</thead>
</table>

**DIAGNOSTIC TEST:**

- Angelman Syndrome (5944)
- Prader-Willi Syndrome (5944)
- Beckwith-Wiedemann Syndrome (5945)
- Prothrombin (Factor 2) Mutation (5953)
- Cystic Fibrosis (5905)
- RET (MEN2/FMTC) Comp (5753)
- Factor 5 Leiden (FVL) Mutation (5946)
- RET Follow-up (5794)
- Fragile X Syndrome (5947)
- Russell-Silver Syndrome
- LCHAD (5934)
- Fragile X-Associated Tremor & Ataxia Syndrome FXTAS (3352)
- MCAD (5909)
- Warfarin Sensitivity (CYP2C9, VKORC1)

**REASON FOR STUDY:**

- [ ] Diagnostic Testing
- [ ] Carrier Detection
- [ ] Prenatal Diagnosis
- [ ] Routine
- [ ] STAT
- [ ] Has genetic counseling by an authorized person been offered? (5946, 5953, and Warfarin exempted)
- [ ] Has informed consent been obtained from the consultant and/or guardian?
- [ ] Has genetic counseling by an authorized person been offered?

**FOR CF STUDY ONLY:**

<table>
<thead>
<tr>
<th>民族 Origins</th>
<th>Father:</th>
<th>Mother:</th>
</tr>
</thead>
</table>

Please enter a short pedigree and any other clinical information below.
**Molecular Diagnostic Laboratory Request for DNA Studies-Oncology**

**COLLECTION INFORMATION**

- **DATE:**
- **TIME:**
- **INITIAL S:**

**ACCOUNT INFORMATION**

- **NAME:**
- **ADDRESS:**
- **CITY:**
- **STATE:**
- **ZIP:**
- **PHONE:**
- **FAX:**

**ORDERING PHYSICIAN**

- **SECOND REPORT TO:**

**BILLS TO:**

- **ACCOUNT:**
- **PATIENT ACCT:**
- **RESEARCH ACCT:**

**REQUEST FOR DNA STUDIES**

**ONCOLOGY**

**PATIENT INFORMATION**

- **LAST NAME:**
- **FIRST:**
- **SEX:**
- **DOB:**
- **ADDRESS:**
- **CITY:**
- **STATE:**
- **ZIP:**
- **PHONE:**

**NARRATIVE DIAGNOSIS**

- **REFERENCE NO:**

**BILLING INFORMATION**

- **ID #:**
- **INSURANCE CO.:**
- **ID #:**
- **ADDRESS:**
- **GROUP #:**
- **PUP #:**
- **PLN NAME:**
- **Patient ID:**
- **INSURED IND:**
- **REGISTERED BY:**
- **CERTIFIED BY:**

**NOTE TO PHYSICIAN:**

When seeking payment from Medicare or Medicaid, Physicians should only order tests that are medically necessary for the diagnosis or treatment of the patient, for instance. Medicare does not cover routine screening, testing that is ‘investigative’ or research use only, testing with quantity limits.

**Laboratory Use Only:**

- **Specimen Condition:**
- **Specimen Number:**
- **Date Received:**
- **Time Received:**

- **Patient**
- **Donor for:**
- **Pre-BMT**
- **Post-BMT**
- **Allogenic**
- **Autologous**

**Sample Type:**

- **B.M.**
- **PB Whole**
- **PB T Lymphocytes**
- **PB Myeloid cells**
- **Lymph node**
- **Other:**

**Tube Type:**

- **Sodium EDTA**
- **ACD**
- **Pantoff Embolized**
- **Frozen**
- **Other:**

**Clinical information:**

Studies cannot be completed without adequate patient identification and requested clinical information.
Flow Cytometry Immunophenotyping Request

Patient Name: ___________________________  Date: ___________
Hospital #: ___________________________  Room#: ___________
D.O.B: ___________________________
Doctor: ___________________________  Beeper #: ___________

Specimen Type:
- Peripheral Blood (1 lavender-top [EDTA] tube and 2 green-top [heparin] tubes) - See below for draw requirements for PNH
- Bone Marrow (1 green-top [heparin] tube)
- Fluid:
- Tissue:
- Other:

Date and Time Obtained: ___________________________

Diagnosis (REQUIRED):

Ruleout:

Test Requested:
- Lymphoma WorkUp (Lymphoproliferative disorder ex: CLL, NHL, HCL)
- Leukemia WorkUp (Acute Leukemia ex AML, ALL, ANLL)
- PNH Profile Includes RBC-CD59, WBC-CD59 and FLAER (1 lavender-top [EDTA] tube and 1 green-top [heparin] tube)
- Sezary Cell Workup
- Other (Please Specify)

If you have any question please call the Barnes-Jewish Flow Cytometry Lab at 362-4628!!
**Allergen Test Request Form (Page 1)**

**ACCOUNT INFORMATION**

**PATIENT**

- **NAME**
- **ADDRESS**
- **DATE OF BIRTH**
- **INSECT**
- **DATE OF BIRTH**
- **REFERRING PHYSICIAN**
- **SEX**
- **ADDRESS**
- **STATE**
- **ZIP CODE**
- **PHONE**
- **DATE OF BIRTH**
- **DATE OF BIRTH**

**INSURANCE**

- **ADDRESS**
- **STATE**
- **ZIP CODE**
- **INSURANCE**
- **EMPLOYER**

**ROUTINE PROFILES 0.1 mL SERUM PER ALLERGEN**

**ALLERGY TEST REQUEST PANELS (see back for details)**

<table>
<thead>
<tr>
<th>MODIFIED REGIONAL SCREEN</th>
<th>FOOD SCREEN</th>
</tr>
</thead>
</table>

**INDIVIDUAL ALLERGENS 0.1 mL SERUM PER ALLERGEN**

**COMMON ALLERGENS**

- **WEEDS**
  - Common ragweed (short)
  - Fireweed (Kochia)
  - Lamb's quarters
  - Rough pigweed
  - Western ragweed
  - Giant ragweed
  - Elm tree
  - Maple (box elder)
  - Mountain maple
  - Oak tree
  - Poison
  - Walnut tree
  - White ash tree
  - White pine tree
  - Willow tree

- **HOUSE DUST MITES**
  - Dermanothrophes Fairene
  - Dermanothrophes Micrasoma
  - Dermanothrophes Peryonius

- **INSECTS & VENOMS**
  - Cockroach
  - Common wasp (yellow jacket)
  - Fire ant
  - Honey Bee
  - Paper wasp
  - Yellow jacket

- **DRUGS**
  - Penicillium G
  - Penicillium V

- **HOUSE DUST**
  - Dust mite (Greer)
  - Dust mite (Hollister-Siler)

**GRASSES**

- Bermuda grass
- Cultivated wheat pollen
- Johnson grass
- Rye grass
- Sweet vernal grass

**EPIDERMAL**

- Cat dander
- Dog dander
- Dog epithelium
- Horse dander

**MOLD**

- Alternaria tenuis
- Aspergillus fumigatus
- Breden eyer chalmydra

**INDIVIDUAL ALLERGENS 0.1 mL SERUM PER ALLERGEN CONTINUED**

**SPECIALIZED ALLERGENS LIST**

**FOOD**

- Alpha-lactalbumin
- Apple
- Beef
- Lactose
- Carvalana canasta
- Episcoporum purpureum

**MOULDS**

- Eurocarious pullulans
- Candida albicans (yeast)
- Candida parapsilosis
- Trichoderma viride

**PARASITES AND INSECTS**

- Cockroach
- Aedes aegypti
- Echinococcus
- Mosquito

**WEEDS**

- Dandelion
- Foliage weed
- Golden Rod
- Lepidota
- Mugwort
- Nettle
- Oxy-eyes daisy

**GRASS POLLEN**

- Bahia grass
- Bromegrass
- Canary grass
- Cock fleece
- Common meadow
- Cultivated oat
- Cultivated rye
- Meadow foxtail
- McClintock foxtail
- Wild rye grass

**OCCUPATIONAL ALLERGENS**

- Latex

**TREE POLLEN**

- Aesculus
- American beach
- Australian pine
- Chestnut
- Common silver birch
- Cottonwood, Poplar
- Douglas fir
- Elder tree

**FORAGE**

- Alfalfa
- Barley
- Oats

**ANIMALS**

- Horse
- Cat
- Dog

**ECZEMA**

- Dermatitis
- Atopic dermatitis

**SHELL FISH**

- Crab
- Lobster

**SHELL FISH**

- Blue mussel
- Shrimp

**SHELL FISH**

- Escullosis (tuna)
- Salmon
- Shrimp
**MO/ILL REGIONAL SCREEN 14 TESTS**

- Dermatoph. pteronyssimus
- Dermatoph. farinae
- House Dust - Hollister-Stier
- Cat Dander
- Dog Dander
- Bermuda Grass
- Rye Grass
- Timothy
- Cladosporium herbarum
- Alternaria tenus
- Maple (Box Elder)
- Oak
- Elm
- Ragweed

**FOOD SCREEN - 11 TESTS**

- Tuna
- Egg White
- Milk
- Orange
- Peanut
- Chicken
- Potato
- Sesame
- Soybean
- Tomato
- Wheat
### Centers for Disease Patient History Form (Page 1)

**STATE HEALTH DEPARTMENT LABORATORY ADDRESS:**

Completed by: 

Date: __/__/____

**STATE HEALTH DEPT. NO.:**

**DATE SENT:** (MM/DD/YYYY) __/__/____

**PATIENT IDENTIFICATION:** (Hospital No.)

**NAME:**

**BIRTHDATE:** __/__/____

**SEX:** MALE ☐ FEMALE ☐

**CLINICAL DIAGNOSIS:**

**ASSOCIATED ILLNESS:**

**DATE OF ONSET:** (MM/DD/YYYY) __/__/____

**FATAL?** YES ☐ NO ☐

---

### Reverse Side of This Form Must Be Completed

This form must be either printed or typed. Please prepare a separate form for each specimen.

**D.A.S.H.**

**DATE REPORTED**

**MO** DA **YR**

---

### Comments:

---

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service
Centers for Disease Control
Center for Infectious Diseases
Atlanta, Georgia 30333

---

*The Centers for Disease Control (CDC), an agency of the Department of Health and Human Services, is authorized to collect this information, including the Social Security number if applicable, under provisions of the Public Health Service Act, Section 317 (42 U.S.C. 241). Sufficient personal information is needed to ensure the proper identification and collection of disease data. The data will be used to enhance public health programs, develop prevention and control programs, and communicate that knowledge to the health community. Data will become part of CDC Privacy Act system 0400-0050. "Personal Identifying Information," such as name, may be disclosed, to appropriate State or local public health agencies and cooperating local authorities for the purpose of contact tracing of infectious disease outbreaks; epidemiologic investigations; disease surveillance; research investigations; or to supply information in the event of a legislated disaster or outbreak. An accounting of the disclosures that have been made by CDC will be made available to the subject individual upon request. Except for laboratory disclosures, approved under the Public Health Service Act, no other disclosures may be made without the express individual written consent.*

---

*CDC 88-34 Rev. 09/2996 (FRONT) – CDC SPECIMEN SUBMISSION FORM –*
### Centers for Disease Patient History Form (Back)

#### LABORATORY EXAMINATION(S) REQUESTED:
- □ Antimicrobial
- □ Susceptibility
- □ Serology
- □ Other (Specify)

#### CATEGORY OF AGENT SUSPECTED:
- □ Bacterial
- □ Fungal
- □ Viral
- □ Other (Specify)

#### SPECIFIC AGENT SUSPECTED:
- □ Other (Specify)

#### OTHER ORGANISM(S) FOUND:

#### ISOLATION ATTEMPTED?
- YES  □
- NO  □

#### NO. OF TIMES ISOLATED:

#### NO. OF TIMES PASSED:

#### SPECIMEN SUBMITTED IS:
- □ Original Material
- □ Mixed Isolate
- □ Pure Isolate

#### DATE SPECIMEN TAKEN:
- □ MD
- □ DA
- □ YR

#### ORIGIN:
- □ Human
- □ Soil
- □ Other (Specify)

#### SOURCE OF SPECIMEN:
- □ Blood
- □ CSF
- □ Wound Site
- □ Gastrointestinal
- □ Urine
- □ Other (Specify)

#### SERUM INFORMATION:
- □ Acute
- □ Convalescent
- □ S1
- □ S2
- □ S3
- □ S4
- □ S5

#### IMMUNIZATIONS:
- □ No
- □ Yes

#### TREATMENT:
- □ Drugs Used
- □ None

#### SIGNED AND SYMPTOMS:
- □ Fever
- □ Headache
- □ other (Specify)

#### CENTRAL NERVOUS SYSTEM:
- □ Meningitis
- □ Meningitis
- □ other (Specify)

#### SKIN:
- □ Acute
- □ Convalescent
- □ Other (Specify)

#### RESPIRATORY:
- □ Mumps
- □ Other

#### CARDIOVASCULAR:
- □ Myocarditis
- □ Encephalitis
- □ Other

#### MICROBIAL:
- □ Pneumonia
- □ Other

#### GASTROINTESTINAL:
- □ Diarrhea
- □ Other

### EPIDEMIOLOGICAL DATA:
- □ Single Case
- □ Epidemic
- □ Other

#### FAMILY HISTORY:
- □ Blood
- □ Other

#### COMMUNITY HISTORY:
- □ Blood
- □ Other

#### TRAVEL AND RESIDENCE (LOCATION):
- □ Foreign
- □ USA

#### ANIMAL CONTACTS:
- □ None
- □ Exposure Only
- □ Bite

#### ANTHROPOD CONTACTS:
- □ None
- □ Exposure Only
- □ Bite

#### TYPE OF ANTHROPOD:
- □ None
- □ Exposure Only
- □ Bite

#### SUSPECTED SOURCE OF INFECTION:

#### PREVIOUS LABORATORY RESULTS/OTHER CLINICAL INFORMATION:

---

**CDC 50:24 Rev. 09/2002 (BACK) — CDC SPECIMEN SUBMISSION FORM —**

---

**CDC NUMBER**
### Clinical Hematology Laboratory Request for Examination of Peripheral Blood Morphology (Front)

#### PATIENT INFORMATION

If no addressograph press hard, fill in name, date, hospital # and date of birth.

#### CLINICAL HEMATOLOGY LABORATORY

REQUEST FOR EXAMINATION OF PERIPHERAL BLOOD MORPHOLOGY

**REQUESTING PHYSICIAN'S NAME**

#### CLINICAL CONDITION SUSPECTED AS A CAUSE OF ABNORMAL MORPHOLOGY

---

#### EXAM REQUESTED

- **RBC MORPHOLOGY**
- **EVALUATION OF LEFT SHIFT ONLY**
- **OTHER (MUST BE SPECIFIED)**

---

### Clinical Hematology Laboratory Request for Examination of Peripheral Blood Morphology (Back)

#### MORPHOLOGICAL EXAMINATION

<table>
<thead>
<tr>
<th>RBC MORPHOLOGY</th>
<th>TARGET CELLS</th>
<th>GRANULOCYTES</th>
<th>LYMPHOCYTES</th>
<th>MONOCYTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANISO</td>
<td>PLATELETS</td>
<td>SEG.</td>
<td>LYMHP</td>
<td>MONO</td>
</tr>
<tr>
<td>POIK</td>
<td>SICKLE CELLS</td>
<td>BAND</td>
<td>BLYMPH</td>
<td>Y MONO</td>
</tr>
<tr>
<td>POLY</td>
<td>PLAT. EVAL.</td>
<td>META</td>
<td>PROLYMPH</td>
<td></td>
</tr>
<tr>
<td>HYPO</td>
<td>PLAT. ENLARGE</td>
<td>MYELO</td>
<td>ATLYMPH</td>
<td></td>
</tr>
<tr>
<td>MACRO</td>
<td>MEG. K. FR.</td>
<td>PROG</td>
<td>AELYMPH</td>
<td></td>
</tr>
<tr>
<td>MICRO</td>
<td>PLAT. CLUMPS</td>
<td>EOS</td>
<td>OTHER SIGNIFICANT FINDINGS</td>
<td>OTHER</td>
</tr>
<tr>
<td>HUB</td>
<td></td>
<td>BASO</td>
<td>BLAST</td>
<td></td>
</tr>
<tr>
<td>BURR</td>
<td></td>
<td></td>
<td>NRBC</td>
<td></td>
</tr>
<tr>
<td>TEAR DROPS</td>
<td></td>
<td></td>
<td>PELGER</td>
<td></td>
</tr>
<tr>
<td>OVAL</td>
<td></td>
<td></td>
<td>AUEER</td>
<td></td>
</tr>
<tr>
<td>BAST</td>
<td></td>
<td></td>
<td>DOHLE</td>
<td></td>
</tr>
<tr>
<td>OTHER</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FINDING(S) IN QUESTION**

**PATHOLOGIST’S FINDINGS**

---

**SAMPLE #**

**PERFORMED BY**

**DATE**

**SIGNATURE / DATE:**