Form 213
Revised 12/2018

"This form, when filled in, contains patient information that must be protected in accordance with the Health Insurance Portability & Accountability Act."

KY Division of Laboratory Services
100 Sower Blvd. Suite 204
Frankfort, Kentucky 40601
Phone: 502/564-4446 Fax: 502/564-7019

Please complete a separate form for each specimen.

Kentucky Public Health
Prevent. Promote. Protect.

Serodiagnosis

PATIENT INFORMATION:

Please Use "L" label or Fill In Completely

Name (Last, First, MI)

Social Security # Sex Race Age Birthdate

Home Address

City State Zip Code County

Send Report To:

Submitter

Street Address (PO BOX)

City State Zip Code

Specimen Information:

Date of Collection _____

Specimen Type: ☐ Serum ☐ Plasma ☐ Whole Blood ☐ CSF

Purpose of Examination:

☐ Diagnostic
☐ Recheck Specimen
☐ Treatment follow-up
☐ Pre-Hepatitis vaccine
☐ Post-Hepatitis vaccine
☐ Needlestick Injury
☐ Immune Status
☐ Prenatal _____ weeks pregnant
☐ Other, specify _____

Routine Examination Requested

☐ **Rubella IgG**

☐ **Syphilis testing**

☐ **Hepatitis A**

☐ **Hepatitis C**

Hepatitis B

☐ HBsAg (Surface Antigen)
☐ anti-HBs (Antibody to HBsAg)
☐ anti-HBc (Antibody to HB Core Antigen)

Special Examinations

☐ Other Serology, Specify _____

Previously Tested? _____
When?_____
Patient an IDU? _____
Patient a MSM? _____
Date of Specimen Refrigeration:_____

Laboratory Findings