Lab Use Only

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

Date: ___/___/_____ Initials:_____

RUBELLA 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 ☐ Family Planning ☐ 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: **Rubella IgG Antibody**	Laboratory Number: *Do Not Write in this Space*

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