ENTERIC BACTERIOLOGY (ENTEROBACTERIACEAE)

N.C. Department of Health and Human Services
State Laboratory of Public Health
4312 District Drive ● P.O. Box 28047
Raleigh, NC 27611-8047

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:

SSN: __ __ __/__ __/__ __ __ __ | 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: __ __/__ __/__ __ __ __

Reason for Testing (ICD-10 Dx Code): __ __ __ __ __ __ __

Specimen Type:
- ❑ Clinical
- ❑ Isolated Organism (describe):_____

Specimen Source:
- ❑ Stool
- ❑ Blood
- ❑ Rectal Swab
- ❑ Urine
- ❑ Wound Site: _____
- ❑ Other: _____

Test Ordered:
- ❑ **Enteric Pathogens**
- ❑ **E. coli 0157/STEC**
- ❑ **Salmonella**
- ❑ **Campylobacter**
- ❑ **Shigella**
- ❑ **Yersinia**
- ❑ **Other** _____

Laboratory Number:

Do Not Write in this Space

Other

Please fill in if applicable

Foreign or domestic travel? Where? _____

Suspect foodborne? Food handler? _____

Daycare?_____