State Laboratories Division
HAWAII STATE DEPARTMENT OF HEALTH
2725 Waimano Home Rd
Pearl City, HI 96782

(PLEASE PRINT LEGIBLY)

STATE LABORATORY NUMBER

DATE RECEIVED

ORDERING/PRIMARY PHYSICIAN:

ADDRESS:
(Street,
City, Zip code)

PHONE NO:

SUBMITTING LABORATORY:

ADDRESS:
(Street,
City, Zip code)

PHONE NO:

I. PATIENT IDENTIFICATION

LAST NAME	FIRST NAME AND MIDDLE INITIAL

ADDRESS (Street, City, Zip code)

PHONE NO:

OCCUPATION	RACE	DATE OF BIRTH	SEX

CLINICAL DIAGNOSIS	DATE OF ONSET	LABORATORY EXAMINATION REQUESTED

CATEGORY OF AGENT SUSPECTED

SPECIFIC AGENT SUSPECTED

II. SPECIMEN INFORMATION

1. SOURCE OF SPECIMEN

☐ HUMAN
☐ OTHER (Specify): _____

2. ORIGINAL MATERIAL SUBMITTED

* TYPE OF SPECIMEN: _____

DATE OF COLLECTION: _____

TRANSPORT MEDIUM: _____

* SPECIFY SITE OF COLLECTION

3. SEROLOGY SPECIMEN

COLLECTION DATE

☐ ACUTE (S1): _____
☐ CONVALESCENT (S2): _____
☐ S3: _____
☐ S4: _____
☐ Other (Specify): _____

4. REFERRED SPECIMEN

☐ PURE ISOLATE
☐ MIXED CULTURE
☐ OTHER (Specify): _____

DATE OF ORIGINAL CULTURE: _____

PRIMARY ISOLATION MEDIA: _____

COLLECTION SITE OF ORIGINAL SPECIMEN: _____

DATE OF CULTURE SUBMITTED AND TRANSPORT MEDIUM USED: _____

SUSPECTED IDENTIFICATION: _____

OTHER ORGANISMS FOUND: _____

OTHER INFORMATION: _____

III. CLINICAL HISTORY

1. CLINICAL SIGNS AND SYMPTOMS

☐ FEVER
☐ EXANTHEMA (Specify Type): _____
☐ RESPIRATORY SIGNS: _____
☐ CENTRAL NERVOUS SYSTEM INVOLVEMENT: _____
☐ GASTROINTESTINAL INVOLVEMENT: _____

2. ADDITIONAL INFORMATION

TRAVEL HISTORY: _____

IMMUNIZATIONS: _____

ANTIBIOTIC THERAPY: _____

3. PREVIOUS LABORATORY RESULTS / OTHER INFORMATION:

DEPARTMENT OF HEALTH USE ONLY

DATE OF REPORT: _____