MISCELLANEOUS EXAMINATION FORM

ARKANSAS
DEPARTMENT OF HEALTH
PUBLIC HEALTH LABORATORY
201 South Monroe
Little Rock, AR 72205

Patient Information (** Required fields)				Submitter Information (** Required fields)	
Patient's Last Name**	First Name**		Middle initial	Submitter ID or #**	Submitter's Name**
Address**				Submitter's Address**	
City**	State**	Zip**	Co. of Residence**		
DOB(mm/dd/yy)**	Sex** O Male O Female	Race**	O White O Black or American African O American Indian/Native Alaska O Asian O Native Hawaiian/Pacific Islander O Other	City**	State** Zip**
Ethnicity**	O Hispanic	O Non-Hispanic	O Unknown	Phone	Contact
Pregnant? O Yes O No O Unknown	If Yes, Expected Date of Delivery?		MM DD YY	Fax	

MISCELLANEOUS EXAMINATION

____ :____ Time Collected**

Date of Onset of Symptoms: ___ / ___ / _______
(required for Arboviral / Rickettsial tests) MM DD Y Y Y Y

Specimen:** _________________________________

Examination Requested:** _________________________________

Requestor Information (Required)

Requestor' s Name** _____________________________________

(Required)

_____ /_____ /____ Date Collected **

PURPOSE (Select One)

O Tuberculosis O Family Planning
O Diagnostic O Recheck specimen
O Contact O Cluster – Suspect
O Rash Present O Lesion Present
O Prenatal O Routine Physical

Notes: This form is for **PRIVATE** submitters only.
O = Select only ONE; ☐ = Check ALL that apply; ** = Required fields; For times, use Military format HH:MM

HL-06
REV. 06/01/2009