

**CONFIDENTIAL REPORT: LABORATORY EVIDENCE OF CERTAIN COMMUNICABLE DISEASES
USE FOR REPORTING TO: MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE**

DO NOT USE FOR TB OR VD

(PLEASE TYPE OR PRINT USING BLACK BALL POINT PEN)

LAST NAME	FIRST	MIDDLE	AGE	RACE	SEX	DATE SPECIMEN SUBMITTED

ADDRESS	CITY	ZIP	COUNTY

ATTENDING PHYSICIAN	ADDRESS OR HOSPITAL

CITY	COUNTY	ZIP	PHONE

LAB ACCESSION NUMBER:

TYPE OF SPECIMEN

Sputum Stool Pharyngeal Swab Discharge

Blood CSF Washing Other _____

TYPE OF TEST

Bacterial Culture Immunological (Specify) _____ Microscopic

Viral Culture Serological (Specify) _____ Histologic

Fungal Culture

RESULTS

DATE OF REPORT	LAB NAME & ADDRESS

DIRECTOR	LAB PHONE