

**OFFICE OF LABORATORY SERVICES**

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PLACE BARCODE HERE

OLS USE ONLY

LYME DISEASE LABORATORY SPECIMEN SUBMISSION FORM**PATIENT INFORMATION**

PATIENT ID (Chart #, etc.) <i>(optional)</i>		
LAST NAME	FIRST NAME	MI
DATE OF BIRTH	SS# (last 4 digits only)	
COUNTY OF RESIDENCE	SEX <input type="checkbox"/> Female <input type="checkbox"/> Male	
STREET ADDRESS		
CITY	STATE	ZIP
PATIENT PHONE NO. <i>(optional)</i>		
RACE <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Other <input type="checkbox"/> American Indian/Alaskan <input type="checkbox"/> Native Hawaiian or other Pacific Islander		
ETHNICITY <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unknown		

DATE OF COLLECTION:**TEST(S) REQUESTED:** EIA for *Borrelia burgdorferi* (Lyme)**SITE/SOURCE OF SPECIMEN:** Blood/serum**CLINICAL SYNDROME(S):** 2nd or 3rd degree atrioventricular block Arthritis characterized by brief attacks of joint swelling Bell's Palsy or other cranial neuritis Encephalitis/encephalomyelitis Erythema migrans present (>5cm) Lymphocytic meningitis Radiculoneuropathy Other (*specify*: _____)**MANDATORY LYME TESTING INFORMATION:**

Travel History (Date/Location):

Date of Symptom(s) Onset:

Has the patient been vaccinated for Lyme disease?

 Yes No

Date of Vaccination (if known):

Was/is the patient pregnant? Yes No**SUBMITTER INFORMATION**

FACILITY NAME		
MAILING ADDRESS		
CITY	STATE	ZIP
COUNTY		
ATTENTION TO:		
PHONE NO.		
FAX NO.		

Comments:

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Reason/ID:

ACC:

DE:

CKD:

FAILURE TO COMPLETE THIS FORM IN ITS ENTIRETY MAY RESULT IN DELAYED TEST RESULTS