

**\*\*NOT AN ORDERING FORM\*\***

This form is only used to document additional demographics for Public Health Reporting for any reportable test.

This form may be updated at any time. Please access this form from the associated test listing each time to ensure current version is in use.

**PATIENT DEMOGRAPHICS FORM FOR PUBLIC HEALTH REPORTING**

Your state or local health department requires testing laboratories to report designated demographic information. Provide this information electronically via an interface or through the use of this form. Failure to provide the required information may result in a follow-up call from your state or local health department.

**Client Information (required)**

Client Name	Client ID
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**Patient Information (required)**

Patient Name (Last, First, Middle)	Patient ID (MRN or other ID#)	Specimen Collection Date
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male    Date of Birth: _____    Race: _____		
Patient's Ethnicity (check all that apply)		
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Unknown/Not Provided

Patient Address	City
County	State    Zip
Patient Phone	

**Physician Information (required)**

Physician Name (Last, First)	Physician Phone
Physician Address	City    State    Zip

**If the patient is a CHILD, please provide the following:**

Parent/ Guardian Name (Last, First)
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**If the patient is an ADULT, please provide the following:**

Patient's Occupation	Patient's Employer Name	Patient's Employer Phone
Patient's Employer Address	City	State    Zip

**ARUP Specimen Processing  
 place master label here.**