Exposed Employee
Lab Worksheet

Last Name ___________________ First Name _________________________ MI ___________

DOB ___________________________ O Male   O Female

Address _____________________________ Telephone # __________________________

City/State/Zip

Test Request:                      Diagnosis:
  o 1968 Hepatitis B Surface Antibody V15.85
  o 1400 Hepatitis C Ab              V15.85
  o 1414 HIV AB                      V15.85
  o ALT                              V15.85

6 week Post Exposure:
  o 1414 HIV AB                      V15.85

3 month Post Exposure
  o 1414 HIV AB                      V15.85

6 month Post Exposure
  o 1414 HIV AB                      V15.85
  o 1400 Hepatitis C Ab              V15.85
  o ALT                              V15.85

Ordering Provider:

Office Phone # __________________ Fax # __________________________

Copy to: Jennifer Huldin, MD
Michigan State University
Olin Health Center
E. Lansing, MI 48824

Bill to: Michigan State University
         Human Resources/ Workman Compensation
         Nesbitt Building Suite 104
         1407 S Harrison Rd
         E. Lansing, MI  48824

          Note: Sparrow Regional Hospital to bill Olin Health Center Account directly.

Date Collected: _________________________ Time: _________________________