

Lab Use Only

Acceptance Criteria Not Met

Inappropriate temperature

Specimen too old

Incomplete labeling/form

Specimen inappropriate/damaged

Date: ___/___/___ Initials: _____

CHLAMYDIA/GONORRHEA DETECTION

N.C. Department of Health and Human Services
 State Laboratory of Public Health
 4312 District Drive • P.O. Box
 28047 Raleigh, NC 27611-8047

Please Give All Information Requested

Attach Printed Label Below

Patient Information	Last Name				
	First Name		MI		
	Maiden Name/Surname				
	Address/Attention:				
	Street Address:		Address 2:	City:	
	State:	Zip Code:	County Code:	County Name:	Phone Number:
	Insurance ID Number: (if applicable)		Medicaid Number (if applicable):		
Medical Record Number:		Date of Birth: ___/___/___	If Female, Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Transgender M2F <input type="checkbox"/> Female <input type="checkbox"/> Transgender F2M <input type="checkbox"/> Unknown <input type="checkbox"/> Transgender Unknown <input type="checkbox"/> Ambiguous		Race (mark all that apply): <input type="checkbox"/> White <input type="checkbox"/> American Indian/ <input type="checkbox"/> Black Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/ <input type="checkbox"/> Unknown Pacific Isles		Ethnicity: <input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	
Clinic/Program Type: <input type="checkbox"/> Prenatal <input type="checkbox"/> STD <input type="checkbox"/> Family Planning <input type="checkbox"/> Outreach <input type="checkbox"/> Student Health Services <input type="checkbox"/> Jail/Detention Centers <input type="checkbox"/> Other (specify): _____					
Submitter	EIN: _____ - _____		Submitter Name:		
	Address:		Address 2:	City:	
	State:		Zip Code:	County Name:	
	Phone Number:		Email Address:	Fax Number:	
	Ordering Provider NPI:		Ordering Provider First and Last Name:		
Specimen	Collection Date: ___/___/___	Collection Time: ___:___	24 Hr Time	Collector's Initials: _____	
	Test ordered: Chlamydia/Gonorrhea Detection		Reason for Testing (ICD-10 Dx Code):		
	Specimen source: <input type="checkbox"/> Vaginal <input type="checkbox"/> Rectal* <input type="checkbox"/> Urine* <input type="checkbox"/> Oropharyngeal*		Laboratory Number(s):		
<i>Do Not Write in this Space</i>					
Other	Please mark Reason for Testing: <input type="checkbox"/> Volunteer/Medical Problem <input type="checkbox"/> Prenatal Visit <input type="checkbox"/> IUD Insertion <input type="checkbox"/> Initial Visit (FP) <input type="checkbox"/> Sex Partner Referral <input type="checkbox"/> Retest (3 months) <input type="checkbox"/> Annual Visit (FP) <input type="checkbox"/> High Risk History <input type="checkbox"/> Signs/Symptoms				
	*Patients must meet one of the following criteria for male urine or extragenital testing (rectal and/or oropharyngeal): <input type="checkbox"/> Asymptomatic MSM or transgender who has had sexual exposure at an extragenital site within the preceding 60 days <input type="checkbox"/> Symptomatic MSM or transgender, regardless of stated date of last exposure <input type="checkbox"/> Symptomatic female who reports rectal and/or oropharyngeal exposures <input type="checkbox"/> Any individual being initiated on or receiving HIV pre-exposure prophylaxis (PrEP) <input type="checkbox"/> Individual who would normally be cultured but requiring molecular testing due to culture media supply issues				