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
Raleigh, NC 27607

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? ☐ Yes ☐ No ☐ Unknown

Sex:
- ☐ Male
- ☐ Female
- ☐ Unknown
- ☐ Ambiguous
- ☐ Transgender M2F
- ☐ Transgender F2M
- ☐ Transgender Unknown

Race (mark all that apply):
- ☐ White
- ☐ Black
- ☐ Asian
- ☐ Unknown
- ☐ American Indian/ Alaska Native
- ☐ Native Hawaiian/ Pacific Isles

Ethnicity:
- ☐ Hispanic or Latino Origin
- ☐ Non-Hispanic
- ☐ Unknown

Clinic/Program Type:
☐ Prenatal ☐ STD ☐ Family Planning ☐ Outreach ☐ Student Health Services
☐ Jail/Detention Centers ☐ 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: ____:____ | Collector's Initials:

Test ordered: **Chlamydia/Gonorrhea Detection** | Reason for Testing (ICD-10 Dx Code):

Specimen source:
- ☐ Vaginal
- ☐ Urine*
- ☐ Rectal*
- ☐ Oropharyngeal*

Laboratory Number(s):

Do Not Write in this Space

Other

Please mark Reason for Testing:
- ☐ Volunteer/Medical Problem
- ☐ Initial Visit (FP)
- ☐ Annual Visit (FP)
- ☐ Prenatal Visit
- ☐ Sex Partner Referral
- ☐ High Risk History
- ☐ IUD Insertion
- ☐ Retest (3 months)
- ☐ Signs/Symptoms

***Patients must meet one of the following criteria for male urine or extragenital testing (rectal and/or oropharyngeal):**
- ❑ Asymptomatic MSM or transgender who has had sexual exposure at an extragenital site within the preceding 60 days
- ❑ Symptomatic MSM or transgender, regardless of stated date of last exposure
- ❑ Symptomatic female who reports rectal and/or oropharyngeal exposures
- ❑ Any individual being initiated on or receiving HIV pre-exposure prophylaxis (PrEP)
- ❑ Individual who would normally be cultured but requiring molecular testing due to culture media supply issues