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:
SSN: ____/____/____			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: ____/____/____	Collector's Initials:
Test ordered: **Chlamydia/Gonorrhea Detection**	Reason for Testing (ICD-10 Dx Code):
Specimen source: ❑ Vaginal ❑ Rectal* ❑ Urine* ❑ Oropharyngeal*	Laboratory Number(s): — — — — — — — *Do Not Write in this Space*

Other

Please mark Reason for Testing:

❑ Volunteer/Medical Problem ❑ Prenatal Visit ❑ IUD Insertion
❑ Initial Visit (FP) ❑ Sex Partner Referral ❑ Retest (3 months)
❑ Annual Visit (FP) ❑ High Risk History ❑ 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