

[1] 1. Last Name		First Name		MI	
2. Patient Number (Soc. Security No.)				- H	
3. Address		4. Date of Birth			
Zip Code		Month	Day	Year	
5. Race <input type="checkbox"/> 1. White <input type="checkbox"/> 2. Black <input type="checkbox"/> 3. American Indian <input type="checkbox"/> 4. Asian <input type="checkbox"/> 5. Native Hawaiian/Pacific Islander <input type="checkbox"/> 6. Unknown					
6. Hispanic or Latino Origin? <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 3. Unknown					
7. Sex <input type="checkbox"/> 1. Male <input type="checkbox"/> 2. Female		8. Co. of Residence			
9. Medicaid Client <input type="checkbox"/> Yes If yes, enter # <input type="checkbox"/> No					

Chlamydia/Gonorrhea Detection

North Carolina
 Department of Health and Human Services
 State Laboratory of Public Health
 Leslie Wolf, PhD, Director
 Virology/Serology Laboratory
 306 North Wilmington Street • P.O. Box 28047
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 Phone: (919) 733-7544
 Fax: (919) 715-7700

[2] Federal Tax No.: _____ Send Report To: _____ _____ Zip Code: _____	[3] Date Collected	State Lab Number
	[4] Date Submitted	
	[5] Date of Onset	

[6] Physician Name: _____	Weekday Phone No.: _____	After-Hours Phone No.: _____	Fax Phone No.: _____
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[7] Clinic Type: <input type="checkbox"/> Family Planning <input type="checkbox"/> STD <input type="checkbox"/> Prenatal <input type="checkbox"/> Jail/Detention Centers <input type="checkbox"/> Student Health Services <input type="checkbox"/> Outreach <input type="checkbox"/> Other _____	[8] Site ID No.: _____
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[9] This Section Must Be Completed

Test Requested: <input checked="" type="checkbox"/> Chlamydia Detection <input checked="" type="checkbox"/> Gonorrhea Detection	Specimen Source: <input type="checkbox"/> Vaginal <input type="checkbox"/> Urine <input type="checkbox"/> Other _____	Signs/Symptoms: <input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnancy Status: <input type="checkbox"/> Yes <input type="checkbox"/> No
Reason for Visit: <input type="checkbox"/> Volunteer/Medical Problem <input type="checkbox"/> Initial Visit (FP)	<input type="checkbox"/> Annual Visit (FP) <input type="checkbox"/> Sex Partner Referral	<input type="checkbox"/> Prenatal Visit <input type="checkbox"/> IUD Insertion	<input type="checkbox"/> High Risk History <input type="checkbox"/> Retest (3 months)

Instructions for Completion of this Form and Specimen Submission

1. Clearly label each specimen with the patient's first and last name, and either date of birth or SSN. Specimens without names or incorrectly labeled specimens will not be tested.
2. Please type or print. To avoid delays in testing, fill out all items in Sections 1 through 9 of the submission form.
3. Send properly identified specimen and completed submission form to the Laboratory as soon as possible.
4. Additional specimen collection kits and goldenrod colored specimen mailers for chlamydia/gonorrhea are available through the NCSLPH online supply ordering system on our website at <http://slph.state.nc.us>.
5. For additional information, see "SCOPE, A Guide to Services" on our website at <http://slph.state.nc.us> or contact the Virology/Serology Laboratory at (919) 733-7544.

FOR LABORATORY USE ONLY

Unsatisfactory Specimen <input type="checkbox"/> No name on specimen <input type="checkbox"/> Name on specimen/form do not match <input type="checkbox"/> Does not meet testing criteria <input type="checkbox"/> Specimen broken/leaked <input type="checkbox"/> Improper source/collection <input type="checkbox"/> Laboratory accident <input type="checkbox"/> Other _____	Comments:
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