CHLAMYDIA/GONORRHEA TEST REQUEST FORM DHHS-4011 INSTRUCTIONS

PURPOSE: The form is to be completed for all patients who are to be tested for Chlamydia/Gonorrhea. Completed forms and specimens are to be sent to the NC State Laboratory of Public Health at the address on the top of the form.

Please Note: If you need additional copies of the submission form, please do NOT photo copy. Instead, print them from the original PDF found on the State Lab’s website or you may call the Virology/Serology office at 919-733-7544 to have an electronic copy emailed to you. This form is designed to be scanned by a computer. A data entry person will manually verify any letters or numbers that the computer cannot interpret. Please help us to save time and improve accuracy by writing carefully and following the instructions below. Please use X instead of √ for check boxes.

Test Requested: Test boxes are pre-marked. Each sample will be tested for both chlamydia and gonorrhea.

Printed Label: Please affix the standardized Patient Information Label/HSIS Laboratory Label if one is available. The standard label format is available from Virology/Serology. Please align the label in the box on the top right of the form. The label must fit within the box, not touch the lines on the edge of the box, and the printed information must be parallel to the top of the box. Labels placed at an angle will not be read accurately.

Patient Information: Complete the information if the standard label/HSIS Laboratory Label is not attached.

- Patient Last Name, First Name, Middle Initial
- Address – patient’s residence – 1st line for house number, street name, etc. 2nd line for apt, suite, etc.
- City – patient’s city of residence
- County - patient’s residence – North Carolina numeric county code, 101 for counties outside of NC.
- State - patient’s residence – Alpha state abbreviation, i.e. NC for North Carolina
- Zip Code - patient’s residence - zip code
- Local Pt ID – Patient ID defined for local use, i.e. chart number.
- SSN – Social Security Number of the patient
- Date of Birth – Month/Day/Year (use a 4-digit year)
- Is the patient on Medicaid? - Mark one box. If patient is unsure, look up Medicaid eligibility if possible before completing.
- Medicaid ID - Medicaid ID number on patient Medicaid card. Look up Medicaid patient number if patient does not have the card.
- Annual Exam Date – For Family Planning patients; Month/Day/Year (use a 4-digit year)
- Dx Code/ICD – Diagnosis Code (ICD9 or ICD10)
- Race – Mark all that apply.
- Ethnicity – Mark one box.
- Sex – Mark one box.
- Clinic Type – Mark one box; specify clinic if marked Other

**Agency:** Please complete the information based on the submitting agency.

- EIN Number – Employment Identification Number with the NCSLPH assigned suffix for specific sites
- Agency Name – please complete as much as possible.

**CT/GC Test Information:** This section must be completed.

- Reason for Visit – Mark one box.
- Signs/Symptoms - Mark one box.
- Pregnancy Status – Mark one box.
- Specimen Source – Mark one box; specify source if marked Other
- Date Collected - Month/Day/Year (use a 4-digit year)

PLEASE DO NOT WRITE IN THE “LAB USE ONLY” AREA OF THE FORM