

# 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

<b>Patient Information</b>	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? <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/ Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian/ Pacific Isles <input type="checkbox"/> Asian <input type="checkbox"/> Unknown		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): _____				
<b>Submitter</b>	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:		
<b>Specimen</b>	Collection Date: _____/_____/_____		Collector's Initials:		
	Test ordered: <b>Chlamydia/Gonorrhea Detection</b>		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>		
<b>Other</b>	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				
	<b>*Patients must meet one of the following criteria for male urine or extragenital testing (rectal and/or oropharyngeal):</b> <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)				