

Specimen Type: Check appropriate specimen and fill in requested information (Only one sample per form).

- Cervix
- Urethra
- Urine
- Other: _____

PATIENT: _____ last _____ first _____

BIRTH DATE: _____ / _____ / _____ mm dd year SSN #: _____ - _____ - _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: (_____) _____ - _____ GENDER: Female Male

RACE: White Black Asian American Indian / Alaskan Native
 Native Hawaiian / Pacific Islander Unknown

ETHNICITY: Hispanic Non Hispanic Unknown

PATIENT ID #: _____

CLINICIAN: _____ last _____ first _____ CLINICIAN ID #: _____
please print

PHONE: (_____) _____ - _____ CLINICIAN'S Signature: _____

DATE COLLECTED: _____ / _____ / _____ mm dd year

Required Program Information

**Chlamydia trachomatis
Neisseria gonorrhoeae
Test Request Form**

Reason for Visit (*check only one*)

- Family Planning / Comprehensive
- STD Screen
- Prenatal
- Rescreen (Positive Chlamydia in the last 3 to 4 months)

Symptoms (*patient reported*)

- Yes
- No

Risk History (*check all that apply*)

- New partner (last 90 days)
- Multiple Partners (last 90 days)
- Contact with STD
- None of the above

Signs / Clinical Impressions (*check all that apply*)

- Cervical friability
- Cervicitis / Mucopurulent cervicitis
- PID Suspicion
- Urethritis
- No exam performed
- None of the above

MEDICAID / MEDICARE INFORMATION

Patient's Medicaid/Medicare #: _____

Physician Provider #: _____

Patient's Medicaid/Medicare ICD9 Code: _____

Referring Physician # (Medipass only): _____

If insurance is primary to Medicaid / Medicare

Insured's Name: _____
please print

Insured's ID#: _____

Insurance Company Name: _____


Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Facility Name: _____

Address: _____

City: _____ State: _____ Zip: _____

 Enter your facility address
Results are returned
to this address

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