Revision 09/2013

STD/HIV Lab Test Request Form

Test Requested: (Mark One) ☐ **Chlamydia/Gonorrhea (CT/GC)** ☐ **Human Immunodeficiency Virus (HIV)** ☐ **Treponema pallidum (Syphilis)**

BOLD PRINT INDICATES REQUIRED INFORMATION. INCOMPLETE INFORMATION MAY CAUSE SPECIMEN REJECTION.

Patient Information

First Name: **Last Name:** Middle Initial: **Date of Birth:** / /

Address: City:

State: Zipcode: Parish:

Marital Status:
☐ Divorced ☐ Widowed
☐ Married ☐ Unknown
☐ Separated ☐ Other
☐ Single

Gender:
☐ Male
☐ Female

Hispanic?

Race:
☐ AI - American Indian/Alaskan Native ☐ AP- Asian Pacific
☐ BL - Black/African American ☐ MR - More than One
☐ PI - Pacific Islander/Native Hawaiian ☐ OT - Other
☐ WH - White/Caucasian ☐ UK - Unknown/Unreported

Medicaid Number	Chart Number	Bayou Health Plan Name	Bayou Health Identification Number

Medical Provider Name	Medical Provider ID Number	Clinic Type or OPH Code

Specimen Information

For test information, see www.lab.dhh.louisiana.gov or email questions to oph.publichealthlab@la.gov

Reason for Test:
☐ Family Planning/Routine GYN ☐ Partner with CT ☐ Partner with Other/Unknown STD
☐ Prenatal ☐ Partner with GC ☐ STD Check-Up (No Symptoms)
☐ Marriage ☐ Partner with Syphilis ☐ STD Symptoms
☐ Follow up after RX ☐ Partner with HIV ☐ Reactive Rapid Test (test type)

Date of Collection: / / **Time:** : Frozen Date and Time:

Specimen Source:
☐ Cervical Swab ☐ Urethral Swab ☐ Urine ☐ Other
☐ Pharyngeal Swab ☐ Rectal Swab ☐ Serum

External Identification or Counseling Form Number

Remember to photocopy this form for your records.

Submitter Information

If you know your StarLims Facility Identification Number, enter it here.

Facility Name:

Facility Address:

Contact Person:

Phone/Fax: /

Optional - Facility Stamp

Ship Specimens to DHH-OPH Central Lab, 1209 Leesville Avenue, Baton Rouge, LA 70802

TO BE COMPLETED BY STATE LABORATORY

LABORATORY NUMBER:

TEMPERATURE:

TUBE EXPIRATION:

Swab	*Serum*	*Urine*

DATE/TIME RECEIVED STAMP: