Revision 07/2019

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 _____

2nd Unique ID (chart#, MR#, EHR#) _____

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

Ordering Provider: _____

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: