

“This form, when filled in, contains patient information that must be protected in accordance with the Health Insurance Portability & Accountability Act.”

Kentucky Public Health Laboratory 100 Sower Blvd., North Loading Dock, P.O. Box 2020 Frankfort, Kentucky 40602-2020 Phone: 502/564-4446 Fax: 502/564-7019	<h2 style="margin: 0;">CHLAMYDIA TRACHOMATIS</h2> <p style="margin: 0;">and</p> <h2 style="margin: 0;">NEISSERIA GONORRHOEAE</h2> <p style="margin: 0;">by Nucleic Acid Amplified Test (NAAT)</p> <p style="margin: 5px 0 0 0;"><i>See information on reverse side</i></p>	
<i>Yellow copy should be retained by the submitter.</i>		
PATIENT INFORMATION:		
Name (Last, First, MI) _____	<i>(Codes defined on reverse side)</i> 1 2 4 5 6 7	
Social Security # Sex Age DOB	Race/Ethnicity <i>(circle one)</i>	
Home Address _____		
City _____	State _____ Zip Code _____ County _____	
Send Report To:		
Health Department _____		
Street Address (PO BOX) _____		
City _____	State _____ Zip Code _____	
<div style="float: right; border: 1px solid black; padding: 5px; width: 100px; text-align: center;"> Please use “L” label or fill in completely </div>		
Reason For Testing: Did the patient present with Chlamydia/GC symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Mark one: <input type="checkbox"/> Volunteer/Medical Problem <input type="checkbox"/> Sex Partner Referral <input type="checkbox"/> Initial (Fam. Plan.) Visit <input type="checkbox"/> Other, please specify _____ <input type="checkbox"/> Revisit/Annual (Fam. Plan.) <input type="checkbox"/> Unknown/Undetermined _____ <input type="checkbox"/> Prenatal Visit <input type="checkbox"/> Cancer		
Specimen Information: Source (mark one): <input type="checkbox"/> Cervical <input type="checkbox"/> Urine <input type="checkbox"/> Urethral <input type="checkbox"/> Other, specify _____ Date of Collection _____ Kit Exp. Date _____ (dd-mmm-yy) (dd-mmm-yy)		
~~~~~ <b>For Laboratory Use Only</b> ~~~~~		
<b>Laboratory Results</b>		
<u>Chlamydia trachomatis</u> <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Equivocal (submit another specimen)	<u>Neisseria gonorrhoeae</u> <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Equivocal (submit another specimen)	<u>Unsatisfactory</u> <input type="checkbox"/> No Specimen Received <input type="checkbox"/> Improper Swabs <input type="checkbox"/> Transport Media Expired <input type="checkbox"/> Other _____
<b>Date and Time Received:</b> _____ <b>Laboratory Number:</b> _____		
<b>Date Reported:</b> _____	<b>Technologist:</b> _____	