West Virginia Department of HEALTH
Office of Laboratory Services
167 11th Avenue | South Charleston, WV 25303
PH: (304) 558-3530 | FX: (304) 558-2006

OLS USE ONLY
[place barcode label HERE]

CT-NG, HIV, SPYHILIS, RUBELLA — DIAGNOSTIC IMMUNOGY LABORATORY SPECIMEN SUBMISSION FORM — CT-NG, HIV, SPYHILIS, RUBELLA

USE ONE FORM PER SPECIMEN

PATIENT INFORMATION

PATIENT ID (Char #, MRN, etc.) Max 17 Characters		
LAST NAME	FIRST NAME	MI
DATE OF BIRTH	SS# (LAST 4 DIGITS ONLY)	
COUNTY OF RESIDENCE	SEX (at Birth) ❒ Female ❒ Male ❒ Not Specified	
STREET ADDRESS		
CITY	STATE	ZIP
PATIENT PHONE NO. (INCLUDE AREA CODE)		
RACE ❒ White ❒ Asian ❒ Black ❒ Other ❒ American Indian/Alaskan ❒ Native Hawaiian or other Pacific Islander	ETHNICITY ❒ Not Hispanic or Latino ❒ Hispanic or Latino ❒ Unknown	
PATIENT TYPE: ❒ Employee ❒ Patient ❒ Investigation		

SUBMITTER INFORMATION

The information below is for the mailing or faxing of test reports. Please make sure the mailing address and fax number are accurate.
OLS should be notified of any changes to this information as soon as possible.

FACILITY NAME		
MAILING ADDDRESS		
CITY	STATE	ZIP
COUNTY		
ATTENTION TO		
PHONE NO. (INCLUDE AREA CODE)		
FAX NO. (INCLUDE AREA CODE		

Provider and /or OLS Notes:

OLS USE ONLY ❒ UNSAT REASON/ID:	**ACC:** **DE:** **CKD:**

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DATE OF COLLECTION:

PROGRAM/CLINIC TYPE (SELECT ONE ONLY)	
❒ FAMILY PLANNING	❒ STD/HIV SERVICES
❒ HOSPITAL	❒ INVESTIGATION
❒ CORRECTIONAL FACILITY	❒ PROJECT HRP
❒ PROJECT # _____	

TEST REQUESTED (SELECT ONE ONLY)	
❒ CT/NG NAAT	❒ RUBELLA SCREEN
❒ HIV PANEL	❒ SYPHILIS SCREEN
SOURCE OF SPECIMEN:	
❒ BLOOD/SERUM	❒ THROAT SWAB
❒ URINE	❒ RECTAL SWAB
	❒ VAGINAL SWAB

IS PATIENT PREGNANT? ❒ N/A ❒ NO ❒ YES: DUE DATE _____

COMPLETE FOR ALL TESTING:	
❒ Routine Screen	❒ Rescreen of previous positive (minimum of three (3) months after treatment)
❒ Any symptom of STD	❒ Suspect/possible contact to STD (new partner, multiple partners, polygamous partner)
❒ Known contact to STD	❒ IUD Insertion

RISK FACTOR INFORMATION (SELECT ALL THAT APPLY)	
PATIENT RISK FACTORS	**PARTNER RISK FACTORS**
❒ Sex with female	❒ Bisexual female
❒ Sex with male	❒ Bisexual male
❒ Injected non-RX drugs	❒ IV injection drug user
❒ Rec'd clotting Factor F VII A and/or F IX B	❒ Person with AIDS or documented HIV+
❒ Received transplant or artificial insemination	❒ Transfusion recipient WITH documented HIV+ and/or transplant WITH documented HIV+
❒ Blood transfusion	❒ Person with hemophilia/clotting disorder
❒ Healthcare worker and/or laboratory worker	**PLACE HIV TEST FORM BARCODE LABEL HERE**
❒ Unspecified Risk(s)	

NOTE: RISK FACTORS FOR NO CHARGE TESTING MUST BE MARKED ON THE FORM AT THE TIME THE SPECIMEN IS RECEIVED FOR EACH REQUESTED TEST.