

1	IF REQUESTING EXAMINATION FOR: HEPATITIS B TEST CODE 2740 COMPLETE ALL THAT APPLY															
<input type="checkbox"/> Pregnancy (HBsAg)			<input type="checkbox"/> Exposure to someone with Hepatitis B			INFECTED PERSON'S DATE OF BIRTH			M	M	D	D	Y	Y	Y	Y
INFECTED PERSON'S NAME																
IF AN INFANT, MOTHER'S NAME																
<input type="checkbox"/> Other (Specify):												<input type="checkbox"/> Court Order		<input type="checkbox"/> At Risk		
2	IF REQUESTING EXAMINATION FOR: SYPHILIS - DFA TEST CODE 2105 COMPLETE THIS SECTION															
Duration of Lesion			<input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Years			Specify Site:										
3	IF REQUESTING EXAMINATION FOR: RABIES ANTIBODY SEROLOGY TEST CODE 2810 COMPLETE THIS SECTION															
Date of Last Rabies Vaccination			M	M	D	D	Y	Y	Y	Y						
4	IF REQUESTING EXAMINATION FOR: LYME BORRELIOSIS TEST CODE 2111 COMPLETE THIS SECTION															
ONSET DATE			M	M	D	D	Y	Y	Y	Y						
EARLY DISEASE		<input type="checkbox"/> Erythema migrans (5 cm at least in diameter)		<input type="checkbox"/> Early Disease Symptoms (Specify): (Ex., Rash, Fever, Headache, Joint Pain)												
LATE DISEASE		<input type="checkbox"/> Neurologic <input type="checkbox"/> Cardiologic <input type="checkbox"/> Rheumatologic			State/County of Exposure											
5	IF REQUESTING EXAMINATION FOR: AEROBIC/ANAEROBIC CULTURE TEST CODES 0200/0300 COMPLETE ALL THAT APPLY															
<input type="checkbox"/> Aerobe <input type="checkbox"/> Anaerobe <input type="checkbox"/> Microaerophile Gram <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Variable <input type="checkbox"/> Rod <input type="checkbox"/> Coccus <input type="checkbox"/> Diplococcus Bacterial Growth Char.: MacConkey <input type="checkbox"/> Pos <input type="checkbox"/> Neg Oxidase <input type="checkbox"/> Pos <input type="checkbox"/> Neg Catalase <input type="checkbox"/> Pos <input type="checkbox"/> Neg Dextrose <input type="checkbox"/> Oxidation <input type="checkbox"/> Fermentation <input type="checkbox"/> Other: _____ _____ _____																

2270	ADENOVIRUS BY CULTURE	0708	LYME DISEASE CULTURE (Human)
0004	AFB SUSCEPTIBILITY - Cultural Isolate	0718	LYME DISEASE CULT. (Non-Human)
0300	ANAEROBIC CULTURE - ID Complete # 5	2111	LYME DISEASE - EIA Complete # 4 Above
2771	ARBOVIRUS ENCEP. PANEL (IgM) §	2113	LYME DISEASE-IFA (Tick or Culture)
0709	AUTOCLAVE TEST STRIPS	0801	NEISSERIA GONORRHOEA - Isolation
2145	BRUCELLA SEROLOGY	0851	NEISSERIA - REFERRED CULTURE
2200	CHLAMYDIA TRACHOMATIS - Culture	0502	PARASITOLOGY - BLOOD
2230	CYTOMEGALOVIRUS CULTURE	0503	PARASITOLOGY - WORM
2580	CYTOMEGALOVIRUS IgG	0750	PERTUSSIS PCR
2400	ENTEROVIRUS BY CULTURE	2105	SYPHILIS DFA Complete # 2 Above
0603	E. COLI (SLT) TOXIN & SEROLOGY	2103	SYPHILIS VDRL - CSF Only
0701	FOODBORNE ILLNESS - Stool or Food	2121	TETANUS TOXIN EIA
2516	FUNGAL IMMUNODIFFUSION	2130	TOXOPLASMA GONDII - IgG
0103	FUNGAL SLIDE & CULTURE	2140	TOXOPLASMA GONDII - IgM
	Clinical Specimens	2220	VARICELLA ZOSTER - CULTURE
2155	FRANCISELLA SEROLOGY	2350	VIRAL RESPIRATORY PANEL - CULT.
2800	HEPATITIS A VIRUS (IgM)		
2590	HERPES SIMPLEX VIRUS IgG		
0400	LEGIONELLA CULTURE		
2110	LEGIONELLA - DFA		
0402	LEGIONELLA - HA		

§ May - October Includes Eastern Equine, California, St. Louis and West Nile.

***Sexually Transmitted Diseases - Definitions**

- Symptoms:** Patient requesting examination due to symptoms, or, symptoms discovered on examination.
Infected Partner: Patient has known exposure to STD (self-reported or documented).
Partner Risk: Patient has multiple sex partners.
History of STD: Patient has been diagnosed with a sexually transmitted disease within last 3 years.
Prenatal Visit: Patient examination is part of prenatal visit.
Age recommended: Recommended age criteria for screening female patients is ≤ 24 for family planning clinics, adolescent and juvenile detention sites, and all ages for STD clinics.
"Plan First!" Clients: A "Plan First!" client seeking family planning services will receive screening and teaching. As a Title X Standards & Guideline requirement, *Chlamydia trachomatis* and *Neisseria gonorrhoeae* screening must be offered to "Plan First!" clients < 24 years of age, prior to provision of a contraceptive method, if risk factors are reported.
Retest: CDC recommends that women testing positive for *N. gonorrhoea* and *Chlamydia trachomatis* be retested approximately 3 months after treatment. Providers are also strongly encouraged to retest all women treated for these infections whenever they seek medical care within the following 3-12 months, regardless of whether the patient believes her sex partners were treated.

¹All tests positive for *Chlamydia* will automatically be tested for *N. gonorrhoeae*.

²The Following Tests Must Have **Prior MDCH Approval**

2961	BACTERIAL TYPING - PFGE
0702	BOTULISM TOXIN
2973	ENTEROVIRUS - PCR
2250	MUMPS - CULTURE
2983	MUMPS - PCR
2820	MEASLES IgM @ CDC
4309	NOVAL INFLUENZA A - PCR
2951	NOROVIRUS - PCR
0450	PERTUSSIS CULTURE
2830	RUBELLA IgM
0602	SALMONELLA SEROTYPING (Non-Human)
2102	SYPHILIS FTA - ABS DS
2109	SYPHILIS IgM WESTERN BLOT
0705	TOXIC SHOCK TESTING