

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"/> Valid Early Disease		<input type="checkbox"/> Erythema migrans (5 cm at least in diameter)	
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
- 0004 AFB SUSCEPTIBILITY - Cultural Isolate
- 0300 ANAEROBIC CULTURE – ID Complete # 5
- 2771 ARBOVIRUS ENCEP. PANEL (IgM) §
- 0709 AUTOCLAVE TEST STRIPS
- 2145 BRUCELLA SEROLOGY
- 2200 CHLAMYDIA TRACHOMATIS – Culture
- 2230 CYTOMEGALOVIRUS CULTURE
- 2580 CYTOMEGALOVIRUS IgG
- 2400 ENTEROVIRUS BY CULTURE
- 0603 E. COLI (SLT) TOXIN & SEROLOGY
- 0701 FOODBORNE ILLNESS - Stool or Food
- 2516 FUNGAL IMMUNODIFFUSION
- 0103 FUNGAL SLIDE & CULTURE Clinical Specimens
- 2155 FRANCISELLA SEROLOGY
- 2860 HANTAVIRUS
- 2800 HEPATITIS A VIRUS (IgM)
- 2590 HERPES SIMPLEX VIRUS IgG
- 2952 HCV - PCR
- 0400 LEGIONELLA CULTURE

- 2110 LEGIONELLA - DFA
- 0402 LEGIONELLA - HA
- 0708 LYME DISEASE CULTURE (Human)
- 0718 LYME DISEASE CULT. (Non-Human)
- 2111 LYME DISEASE - EIA Complete # 4 Above
- 2113 LYME DISEASE-IFA (Tick or Culture)
- 0801 NEISSERIA GONORRHOEAE - Isolation
- 0851 NEISSERIA - REFERRED CULTURE
- 0502 PARASITOLOGY - BLOOD
- 0503 PARASITOLOGY - WORM
- 0750 PERTUSSIS PCR
- 2105 SYPHILIS DFA Complete # 2 Above
- 2103 SYPHILIS VDRL - CSF Only
- 2121 TETANUS TOXIN EIA
- 2130 TOXOPLASMA GONDII - IgG
- 2140 TOXOPLASMA GONDII – IgM
- 2220 VARICELLA ZOSTER – CULTURE
- 2350 VIRAL RESPIRATORY PANEL – CULT.

§ 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.
- IUD Insertion:** Title X mandates that clients who are provided with Intrauterine Device (IUD) insertion must be tested for *N. gonorrhoea* and *Chlamydia trachomatis* for diagnostic purposes and/or for maintenance of health status.

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
- 2954 HEPATITIS A VIRUS – PCR
- 2950 HIV – PCR
- 2250 MUMPS - CULTURE
- 2983 MUMPS - PCR
- 2820 MEASLES IgM
- 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