

Chlamydia trachomatis (Non-Culture)

State of Michigan - Regional Laboratory Test Requisition

Date Received in Laboratory					Regional Laboratory Sample #																
Michigan Department of Community Health - Bureau of Laboratories 3350 N. Martin Luther King Blvd. PO Box 30035 Lansing Michigan 48909 Laboratory Records: 517-335-8059 Technical Information: 517-335-8067 Fax 517-335-9871 HTTP://www.michigan.gov/mdchlab					Saginaw County Health Department 1600 North Michigan Saginaw Michigan 48602 Phone: 989-758-3825 Fax: 989-758-3755																
1	SUBMITTER INFORMATION - ENTER AGENCY CODE (IF KNOWN)																				
RETURN RESULTS TO:					<input type="checkbox"/> PHONE <input type="checkbox"/> FAX																
CONTACT PERSON/REFERRING PHYSICIAN/PROVIDER NAME					NATIONAL PROVIDER IDENTIFIER NUMBER																
2											3										
DATE OF COLLECTION					TIME COLLECTED																
4	M	M	D	D	Y	Y	Y	Y	5									<input type="checkbox"/> AM	<input type="checkbox"/> PM		
PATIENT NAME (LAST, FIRST, MIDDLE INITIAL OR UNIQUE IDENTIFIER)					MUST MATCH SPECIMEN LABEL EXACTLY																
6																					
PATIENT'S CITY OF RESIDENCE					ZIP CODE																
7																8					
TEST REQUESTED AND SPECIMEN SOURCE (CHOOSE ONLY ONE SOURCE)																					
9	<input type="checkbox"/> <i>C. trachomatis</i> only (non-culture)																				
10	<input type="checkbox"/> CERVIX <input type="checkbox"/> RECTUM <input type="checkbox"/> PHARYNX <input type="checkbox"/> URETHRA <input type="checkbox"/> URINE <input type="checkbox"/> VAGINA (LANSING ONLY) (LANSING ONLY)																				
GENDER					RACE (CHECK ALL THAT APPLY)																
11	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE				12	<input type="checkbox"/> Black/AA <input type="checkbox"/> White <input type="checkbox"/> Native American or Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian/PI <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify):															
ETHNICITY					SUBMITTER'S PATIENT NUMBER (IF APPLICABLE)																
13	HISPANIC <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN ARAB DESCENT <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN				14																
DATE OF BIRTH					MEDICAID NUMBER/PLAN FIRST NUMBER																
15	M	M	D	D	Y	Y	Y	Y	16												
SYMPTOMS OR DIAGNOSIS																					
17	<input type="checkbox"/> CERVICITIS <input type="checkbox"/> URETHRITIS <input type="checkbox"/> OTHER (SPECIFY): _____																				
SUBMITTER SPECIMEN NUMBER					SEXUALLY TRANSMITTED DISEASES - REASON FOR TESTING (SEE REVERSE FOR DEFINITIONS)																
18					19	CHECK ALL THAT APPLY <input type="checkbox"/> Symptoms <input type="checkbox"/> History of STD (< 3years) <input type="checkbox"/> Retest <input type="checkbox"/> Infected Partner <input type="checkbox"/> Age Recommended for Testing <input type="checkbox"/> Partner Risk <input type="checkbox"/> "Plan First!" Client Prenatal Visit <input type="checkbox"/> Medicaid other than "Plan First!" Client															

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. *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.
- NOTE:** In order to ensure proper billing, verify the box for either “Plan First!” or Medicaid is marked in the STD – Reason for Testing field.

- FP STD:** This field is to be completed by sites which receive pre-paid form allocations from the Michigan Department of Community Health Title X Family Planning Program, **AND** Sexually Transmitted Disease Section. Completion of this field will assist us in more accurately estimating utilization and subsequent need for pre-paid test resources.
- Zip Code:** Patient zip code data is used to calculate screening rates in local jurisdictions and compare them to infection. The resulting information can be used to better target resources and testing.

Specimen Collection: Specimens must be collected using the appropriate collection kit as shown below. Specimens received in the wrong collection kit will not be tested and reported as “Unsatisfactory”.

Specimen Source	Collection Kit
Endocervix, Urethra, Rectum, Pharynx	Aptima Unisex Swab
Urine	Aptima Urine Collection Kit
Vagina	Aptima Vaginal Swab

Rectal or Pharyngeal Swabs: Limited testing of rectal and/or pharyngeal specimens is only available in the Lansing laboratory. This is not intended for population based screening; MDCH recommends the use of this test only for patients with symptoms or known exposure.