

**NEW- Mandatory- fill in TRAB box or include TRAB name on your label or stamp.**

Specimen Source must be completed  
Test Request: Chlamydia/GC NAAT  
barcode  
13CT0001 Valid 1-1-13 to 12-31-13

STATE LAB  
Use Only

The sticker itself is the CT/GC NAAT test request. Affix one blue sticker to the upper left corner of the lab slip.

You must provide the specimen source in the space on the sticker

Collect date must be completed

Collect Date: \_\_\_\_\_  
Reason for Test:  Screening  Diagnostic  Contact  Test of Cure  2-3 Months Post Rx  Suspected Carrier  Isolate for ID  Release

The sticker replaces the need to mark this box.

Complete submitter and patient information sections including sex, ethnicity and race.

In MyLIMS, select Chlamydia and Gonorrhea Nucleic Acid Amplification.

Visit the lab website for updates:  
[dhmh.maryland.gov/laboratories](http://dhmh.maryland.gov/laboratories)

Use only these codes for specimen source. Write it in the space provided on the blue sticker.

INFECTIONIOUS AGENTS: CULTURE/DETECTION

DEPARTMENT OF HEALTH AND MENTAL HYGIENE, STATE OF MARYLAND  
 Laboratory Information System (LIMS) - Patient Information Form  
 Form ID: 1303-0001 (Rev. 12/12/12)

STATE LAB Use Only

Specimen Source: \_\_\_\_\_  
 Test Request: Chlamydia/GC NAAT  
 barcode: 13CT0001 Valid 1-1-13 to 12-31-13

INFECTIONIOUS AGENTS: CULTURE/DETECTION

Patient SS# (last 4 digits): \_\_\_\_\_  
 Last Name: \_\_\_\_\_ GSR  JR  Other \_\_\_\_\_  
 First Name: \_\_\_\_\_ Maiden: \_\_\_\_\_  
 Date of Birth (mm/dd/yyyy): \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 County: \_\_\_\_\_  
 Phone# \_\_\_\_\_ Fax# \_\_\_\_\_  
 Test Request Authorized by: \_\_\_\_\_  
 Sex:  Male  Female  Transgender M to F  Transgender F to M  
 Ethnicity: Hispanic or Latino Origin?  yes  no  
 Race:  American Indian/Alaska Native  Asian  Black/African American  Native Hawaiian/Other Pacific Islander  White  
 Outbreak # \_\_\_\_\_ Submitter Lab# \_\_\_\_\_  
 Collect Date: \_\_\_\_\_ Collect Time: \_\_\_\_\_  
 Reason for Test:  Screening  Diagnostic  Contact  Test of Cure  2-3 Months Post Rx  Suspected Carrier  Isolate for ID  Release  
 Therapy/Drug Treatment:  No  Yes Therapy/Drug Type: \_\_\_\_\_ Therapy/Drug Date: \_\_\_\_\_

SPECIMEN CODE: \_\_\_\_\_

SPECIMEN CODE	SPECIMEN CODE	SPECIMEN CODE
<b>BACTERIOLOGY</b>	<b>MYCOBACTERIOLOGY/AFB/TB</b>	<b>RESTRICTED TESTS</b>
Bacterial Culture - Routine	AFB/TB Culture and Smear	Pre-approved submissions only
Additional specimen codes:	AFB/TB Referred Culture for ID	Chlamydia trachomatis/GC NAAT
<i>Bordetella pertussis</i>	M. tuberculosis Referred Culture for Genotyping	Chlamydia trachomatis only/NAAT
Group A Strep	Nucleic Acid Amplification Test for M. tuberculosis Complex (MTD)	Norovirus ** (see comment on back)
Group B Strep Screen	<b>PARASITOLOGY</b>	<b>OTHER TESTS FOR INFECTIOUS AGENTS</b>
C. difficile Toxin	Blood Parasites:	Test name: _____
Diphtheria	Country visited outside US: _____	Prior arrangements have been made with the following DHMH Laboratories Administration employee: _____
Foodborne Pathogens ( <i>B. cereus</i> , <i>C. perfringens</i> , <i>S. aureus</i> )	Ova & Parasites - Immigrant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Gonorrhea Culture: incubated? <input type="checkbox"/> yes <input type="checkbox"/> no	Cryptosporidium	
hrs. incubated: _____ Add'l specimen codes: _____	Cyclospora/Isospora	
MRSA (rule out)	Microsporidium	
VRE (rule out)	Pinworm	
<b>ENTERIC INFECTIONS</b>	<b>VIRUS ISOLATION/CHLAMYDIA</b>	
Campylobacter	Adenovirus*	
E. coli O157 typing	Arbovirus Panel (WNV, EEEV, SLEV)	
Enteric Culture - Routine (Salmonella, Shigella, E. coli O157, Campylobacter)	Chlamydia trachomatis	
Salmonella typing	Cytomegalovirus (CMV)	
Shigella typing	Enterovirus (Inc. Echo & Coxsackie)	
<i>V. parahaemolyticus</i>	Herpes Simplex Virus (Types 1 & 2)	
Yersinia	Influenza (Types A & B)	
<b>REFERENCE MICROBIOLOGY</b>	Parainfluenza (Types 1, 2 & 3)*	
ABC# (BIDS) # _____	Respiratory Syncytial Virus (RSV)*	
Organism: _____	Varicella (VZV)	
Bacteria Referred Culture for ID		
Specify: _____		

\*MAY INCLUDE RESPIRATORY SCREENING PANEL

Comments: \_\_\_\_\_

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2013  
Chlamydia/GC  
Allocation