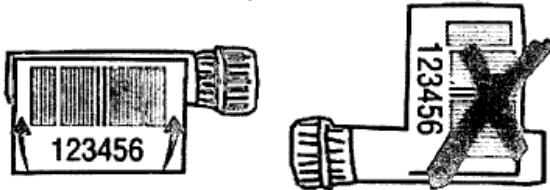


Appendix M. STD Test Request

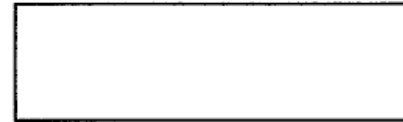
ILLINOIS DEPARTMENT OF PUBLIC HEALTH LABORATORIES
STD/HIV TEST REQUEST

- 1 Print firmly and neatly.
- 2 Use only pens with dark ink.
- 3 Fill in circles. **LIKE THIS:** ● **NOT:** ⊗ ⊕
Mark your MISTAKES like this: ⊗
- 4 Use capital letters only and print letters and numbers completely inside boxes:
A B C 1 2 3
- 5 Please complete all items on form.

NOTE: THE ENTIRE LABEL MUST BE APPLIED LENGTHWISE ON THE COLLECTION TUBE. ENTIRE BAR CODE MUST BE VISIBLE AND SCANNABLE LENGTHWISE! (SEE DIAGRAM BELOW).



Place specimen bar code label in box below.



PROVIDER INFORMATION:

PROVIDER CODE _____ CLINICIAN'S LAST NAME _____

PATIENT INFORMATION:

PATIENT'S FIRST NAME _____

PATIENT'S LAST NAME _____

IDPH APPROVED LABEL ONLY
AFFIX LABEL UPRIGHT AND LEVEL!!!
CALL 217-782-6562 FOR INFORMATION

PATIENT'S ID # _____ SEX M F PREGNANT? Y N BIRTHDATE ____/____/____ AGE ____

MEDICAID RECIPIENT ID # _____ RACE White African American/Black Native American Asian/Pacific Islander Unknown Other ETHNICITY Hispanic Non-Hispanic Unknown

STREET ADDRESS (Please include Apartment/Suite number) _____

CITY _____ STATE _____ ZIP CODE _____

TEST REQUESTED INFORMATION:

DATE COLLECTED ____/____/____ INITIALS OF PERSON COMPLETING FORM _____ **PLEASE INDICATE TEST(S) REQUESTED - Tests requested from unauthorized sites will be rejected.**

<input type="radio"/> HIV SOURCE <input type="radio"/> Venous <input type="radio"/> Oral Fluid PREVIOUS TEST RESULT(s) <input type="radio"/> Positive <input type="radio"/> Indeterminate (HIV Only) <input type="radio"/> Rapid Test Positive		<input type="radio"/> CONORRHEA/CHLAMYDIA SOURCE <input type="radio"/> Swab (Urogenital) <input type="radio"/> Urine REASON (Choose All That Apply) <input type="radio"/> Signs/Symptoms <input type="radio"/> Sex Partner CT <input type="radio"/> Sex Partner GC <input type="radio"/> Sex Partner Risk <input type="radio"/> Age <input type="radio"/> IUD Insertion <input type="radio"/> Re-screen (CT Positive Prior 3-4 mo.) <input type="radio"/> STD History (<3 yrs) <input type="radio"/> Prenatal		<input type="radio"/> SYPHILIS REASON (Choose All That Apply) <input type="radio"/> Signs/Symptoms <input type="radio"/> Previous Syphilis Rx <input type="radio"/> Confirmation Test <input type="radio"/> Prenatal <input type="radio"/> Screening <input type="radio"/> Sex Partner
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LAB USE ONLY

LAB STAMP ONLY

26513