Saginaw County Health Department Laboratory Clinical Test Requisition

1600 North Michigan Avenue Room 102 Saginaw, MI 48602
989-758-3825 Fax 989-758-3755

Date Received	Sample #

SPECIMEN INFORMATION

1	O *C. trachomatis* and *N. gonorrhoeae* *(non-culture)* ☐ Vaginal ☐ Urethral ☐ Urine ☐ Anal/Rectal ☐ Endocervical ☐ Pharyngeal	O *Trichomonas vaginosis* ☐ Vaginal ☐ Urine ☐ Endocervical	O Direct smear for *N. Gonorrhoeae* ■ Urethra	O VDRL ■ Serum

ICD-10 DIAGNOSIS CODES
☐ Z30.9 (Contraceptive Management) ☐ Z11.3 (STI Screening for Sexual Infection)

DATE COLLECTED (MM/DD/YYYY)

2											

3	**SUBMITTER INFORMATION**	ENTER AGENCY CODE (IF KNOWN)										
Return Results to:		FP O	Phone									
		STD O	Fax									

CONTACT PERSON/ORDERING PHYSICIAN/PROVIDER NAME		NATIONAL PROVIDER IDENTIFIER #									
4		5									

PATIENT INFORMATION

NAME (Last, First, Middle Initial) **Must Match Specimen Label Exactly**

6																		

DATE OF BIRTH (MM/DD/YYYY)									GENDER		
7									8	Male O	Female O

PATIENT'S CITY OF RESIDENCE												ZIP CODE					
9												10					

RACE (Check all that apply)

11	O Black	O Native American or Alaskan	O White	O Hawaiian/PI	O Asian	O Unknown
	O Other (specify) _____					

ETHNICITY		SUBMITTER'S PATIENT # (if applicable)											
12	Hispanic O Yes O No O Unknown Arab Descent O Yes O No O Unknown	13											

BILLING INFORMATION (complete all areas that apply)

MEDICAID/PLAN FIRST #

O **CONFIDENTIAL TESTING** (Only **MEDICAID** will be billed: patient/submitter is responsible for test cost.)

O Bill the submitter.

14 **INSURANCE PROVIDER** or **HEALTHY MICHIGAN PLAN HMO**:

SUBSCRIBER'S NAME (Last, First, Middle Initial) & SUBSCRIBER'S DATE OF BIRTH

15

RELATIONSHIP TO SUBSCRIBER		GROUP #										
16	O Self O Spouse O Dependent	17										

POLICY/CONTRACT #

18																		

REASON FOR TESTING

19 O Symptoms O History of STD O Age O Infected Partner O Partner Risk O Prenatal Visit O Retest O Test of Cure (GC)