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 □ Urethra □ Urine □ Endocervical	O *Trichomonas vaginosis* □ Vaginal □ Urine □ Endocervical	O *N. gonorrhoeae* – Culture □ Urethra □ Anal □ Pharynx □ Cervix	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 MEDICAID/PLAN FIRST #

(complete all areas that apply)

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

O Bill the submitter.

14 INSURANCE PROVIDER OTHER THAN MEDICAID 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)