Instructions: Immunology Test Request Form

Each form must be filled out completely and legibly. (Please print.) Errors must be crossed out and correction written above the error, NO white-out should be used. A copy of the form is available for electronic completion by accessing the SPHL website at: https://webapp01.dhss.mo.gov/LIMSForm_APP/SelectTest.aspx.

An Immunology Test Request Form is required for all Ct/GC specimens submitted to the SPHL. If submitting syphilis and/or HIV testing for a client also receiving Ct/GC testing, providers must complete a separate request form and specifically mark the sections for the syphilis/HIV specimen. Syphilis and HIV testing can be performed from the same specimen sample if there is sufficient volume.

Submitter Information Section

- **Submitter Number; Facility Name; Address; City; State; Zip Code:** The Submitter Number is the Internal Control Number (ICN) assigned by the State Public Health Laboratory and must be included on each form. If accessing this form electronically from the SPHL website the Submitter Number and the associated demographics fields for Facility Name, Address, City, State and Zip Code will auto-populate.
  - **Outside Facility Number/Name:** Use of the Outside Facility Number/Name field is not recommended unless special circumstances exist to warrant results being sent to another facility address, i.e., some providers have satellite sites with limited clinic availability and want results to be sent to the main agency address, which has been assigned a different ICN number. The facility whose ICN number is recorded in the Submitter Number field is the only address where results will be sent.
- **Submitter Contact Name and Submitter Telephone Number:** must be entered manually on the form.

**NOTE:** If there is no Submitter Number listed, the SPHL will try to contact the facility to submit a new request form with their identifying information. If a new request form is not received, the specimen will be considered unsatisfactory for testing and not tested.

Attending Physician/Clinician Information Section

- Record the name of the physician/clinician responsible for oversight of the ordering and/or submitting of the test specimen, along with the physician/clinician demographics of telephone number and full address.

Patient Information Section

- **Patient ID** – Optional field.
- **Outreach Event** – Optional field.
- **Last Name; First Name:** The name on the form must be identical to the name on the specimen tube or the specimen will be considered unsatisfactory for testing and not tested.
- **Address; City; State; Zip Code:** Complete fully
- **Gender:** Mark the appropriate gender check box for the patient: F (Female); M (Male); M2F (Male to Female); or F2M (Female to Male).
- **Birth date** – Complete in the format of mm/dd/yyyy (i.e. February 8, 2012 = 02/08/2012). Date of Birth must be recorded on the specimen tube.
- **Ethnicity:** Mark the appropriate check box: Hispanic; non-Hispanic; or Unknown.
- **Race:** Mark the appropriate check box(es): White; Black/African American; Asian; American Indian/Alaskan Native; Native Hawaiian/Pacific Islander; Other; or Unknown. (It is acceptable for the patient to identify more than one race.) *It is recommended that the patient identify the race rather than the health professional assigning a race. For those patients who choose not to identify a race, mark Unknown.*
- **Medical Record Chart ID:** Optional field.
- **Medicaid Number:** Record the patient’s Medicaid number (DCN number) if available (The SPHL does not currently collect re-imbursement from other/private insurance providers.)
- **Patient’s County of Residence:** Record the patient’s county of residence.

**Test Requested/Specimen Type Section**
- **Date Specimen Collected:** Complete in the format of mm/dd/yyyy (i.e. February 8, 2012 = 02/08/2012). Date Specimen Collected must be recorded on the specimen tube.
- **Specimen ID (Local Use):** Optional field.
- **Syphilis Testing:** Mark the appropriate check box: Serum/Blood; or CSF (cerebrospinal fluid).
- **HIV Testing:** Mark the appropriate check box: Serum/Blood; or Plasma.
- **Chlamydia/Gonorrhea Testing:** Mark the appropriate check box: Endocervical swab; Vaginal swab; Urethral swab; Rectal swab; Urine; or Pharyngeal swab.

**Patient History**
- **Syphilis:** Mark the appropriate check box only if applicable; Suspected Latent; or Previous Reactive.
- **HIV Rapid Testing:** Mark the Preliminary Positive box only if applicable. This box only applies to sites performing rapid HIV testing.
- **Insurance Information – Check only one:** Mark the appropriate check box: Private; Uninsured; Unknown; Medicare; Medicaid; Military or CHIP.
- **Patient Pregnant:** Mark appropriate check box; Yes; No; or Unknown.
- **Chlamydia and Gonorrhea - Check all that apply:**
  - **Screening Criteria** (One test per 12 month period)
    - Female age 15-24 AND ≥ 1 partner (last 12 months)
    - Female age 25-44 AND Either New partner (last 60 days) OR ≥ 2partners (last 12 months)
    - Male with ≥ 1 male sex partner (last 12 months)
  - **Testing Criteria** (Males and Females ≥ 12 years of age)
    - Contact to a CT/GC positive client
    - Rescreen (3-12 month post-treatment only)
    - Signs/Symptoms

*Note: Screening Criteria* refers annual Ct/GC testing – not requiring symptoms or known exposure. Clients
screened in the previous 12 months can only be retested if meeting **Testing Criteria**.

**Remarks**
- This area can be used for notes. This information will not be collected or entered into a database or reflected as part of the Results Report.