Priority Health Member ☐

Michigan Regional Laboratories Test Requisition

Detroit City Health Department
1151 Taylor Street
Detroit MI 48202
313-876-4220 Fax 313-876-4221

Kalamazoo County HCS Laboratory
3299 Gull Road
Nazareth MI 49074
269-373-5360 Fax 269-373-5216

Kent County Health Department
700 Fuller N.E.
Grand Rapids MI 49503
616-632-7210 Fax 616-632-6899

Saginaw County Health Department
1600 North Michigan
Saginaw MI 48602
989-758-3825 Fax 989-758-3755

Date Received in Laboratory	Time Received In Laboratory	Regional Laboratory Sample Number

1 **SUBMITTER INFORMATION - ENTER EPIC CODE IF KNOWN** >>>>>>>>>>>>>>>>>>>>

Return Results to:

Phone

Fax

CONTACT PERSON/REFERRING PHYSICIAN/PROVIDER NAME **NATIONAL PROVIDER IDENTIFIER (Required for Medicaid Transactions)**

2 **3**

4 **INDICATE TEST REQUESTED - The following four tests are available from all of the Regional Laboratories**

C. trachomatis (Non-Culture)[1] Enteric Culture Food Microbiology

The following test is available from the Detroit City & Kent County Laboratories ONLY-DO NOT SEND to the Lansing Laboratory

HIV-1/HIV-2 **MUST COMPLETE REVERSE OF THIS FORM (22 through 33)**

DATE OF COLLECTION **TIME COLLECTED**

5 M M D D Y Y Y Y **6** AM PM

SPECIMEN SOURCE

7 Cervix Urethra Serum Stool Urine Other (Specify) _____

PATIENT NAME (LAST, FIRST, MIDDLE INITIAL OR UNIQUE IDENTIFIER) **Must Match Specimen Label Exactly**

8

SUBMITTER PATIENT NUMBER – If Applicable

9

PATIENT'S CITY OF RESIDENCE **ZIP CODE**

10 **11**

GENDER **RACE**

12 Female Male **13** Black/AA White Native American or Alaskan Asian Hawaiian/PI Unknown Other (Specify):

ETHNICITY **DATE OF BIRTH**

14 Hispanic Yes No Unknown
Arab Descent Yes No Unknown

15 M M D D Y Y Y Y

MEDICAID NUMBER **PLAN FIRST NUMBER (Check One – As Appropriate)** **SYMPTOMS OR DIAGNOSIS**

16 **17** Diarrhea Cervicitis Fever Urethritis Nausea Other (Specify):

SUBMITTER SPECIMEN NUMBER **SEXUALLY TRANSMITTED DISEASES - REASON FOR TESTING (If Applicable) See Reverse For Definitions**

17 **18** **Check All That Apply**

Symptoms Prenatal Visit
Infected Partner Age Recommended for Testing
Partner Risk **"Plan First!" Client**
History of STD (< 3years) Retest

OUTBREAK IDENTIFIER (Foodborne ONLY - If Applicable)

19

ORGANISM SUSPECTED (Foodborne ONLY - If Applicable)

20

COMMENTS/OTHER

21	

The following questions must be completed for HIV-1/HIV-2 Testing:

TYPE OF TUBE USED FOR BLOOD DRAW

22	Clot tube (red-top for serum) SST tube (red and gray tiger top tube – for serum) Other (specify) _____

DATE OF CENTRIFUGATION									TIME OF CENTRIFUGATION						
23	M	M	D	D	Y	Y	Y	Y	24					AM	PM

DATE OF POURING OFF (SERUM)									TIME OF POURING OFF (SERUM)						
25	M	M	D	D	Y	Y	Y	Y	26					AM	PM

TOTAL VOLUME OF SERUM SENT FOR HIV TESTING

27	_____ . _____mL

SERUM CONDITION

28	No Hemolysis Low Hemolysis Moderate Hemolysis High Hemolysis Lipemic Contaminated

DATE OF COURIER PICK UP									TIME OF COURIER PICK UP						
29	M	M	D	D	Y	Y	Y	Y	30					AM	PM

IF APPLICABLE:

DATE SAMPLE FROZEN AT –70 CELSIUS									TIME SAMPLE FROZEN AT –70 CELSIUS						
31	M	M	D	D	Y	Y	Y	Y	32					AM	PM

SAMPLE KNOWN TO BE INELIGIBLE FOR GENOTYPE TESTING - EXPLANATION

33	

Sexually Transmitted Diseases – Definitions

Symptoms:	Patient requesting examination due to symptoms, or, symptoms discovered on examination.
Infected Partner:	Patient has known exposure to STD (self-reported or documented).
Partner Risk:	Patient has multiple sex partners.
History of STD:	Patient has been diagnosed with a sexually transmitted disease within last 3 years.
Prenatal Visit:	Patient examination is part of prenatal visit.
Age recommended:	Recommended age criteria for screening female patients is ≤ 24 for family planning clinics, adolescent and juvenile detention sites, and all ages for STD clinics.
"Plan First!" Clients:	A "Plan First!" client seeking family planning services will receive screening and teaching. *Chlamydia trachomatis* and *Neisseria gonorrhoeae* screening must be offered to "Plan First!" clients < 24 years of age, prior to provision of a contraceptive method, if risk factors are reported.
Retest:	CDC recommends that women testing positive for *N. gonorrhea* and *Chlamydia trachomatis* be retested approximately 3 months after treatment. Providers are also strongly encouraged to retest all women treated for these infections whenever they seek medical care within the following 3-12 months, regardless of whether the patient believes her sex partners were treated.

[1]All tests positive for *Chlamydia* will automatically be tested for *N. gonorrhoeae.*