One lab slip MUST be completed for each sample submitted.

Fill in TRAB box or include TRAB name on your label or stamp.

Collect date must be completed

The sticker replaces the need to mark this box.

Use only these codes for specimen source. Write specimen source code in the space provided on the Purple sticker. (CX, R, V, URE, T, or UFV)

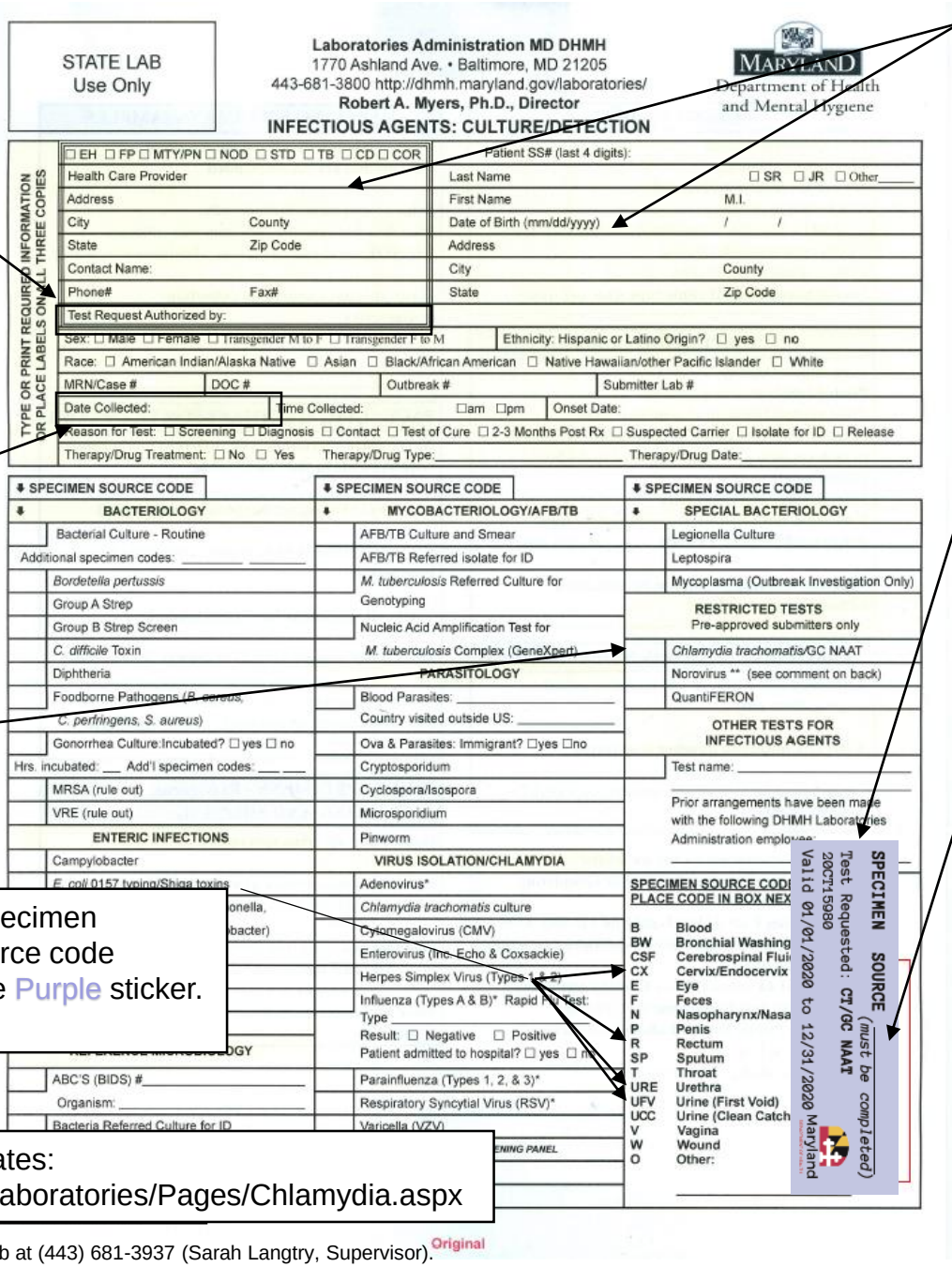
Visit the lab website for updates: https://health.maryland.gov/laboratories/Pages/Chlamydia.aspx

Complete submitter and patient information sections including sex, ethnicity and race.

The sticker itself is the CT/GC NAAT test request. Affix one Purple sticker to the lower right corner of the lab slip.

You must provide the specimen source in the space on the sticker: **CX, R, URE, UFV, V, T**

2021
Chlamydia/GC NAAT Sticker Allocation


STATE LAB Use Only

Laboratories Administration MD DHMH
1770 Ashland Ave. • Baltimore, MD 21205
443-681-3800 http://dhmh.maryland.gov/laboratories/
Robert A. Myers, Ph.D., Director

MARYLAND Department of Health and Mental Hygiene

INFECTIOUS AGENTS: CULTURE/DETECTION

TYPE OR PRINT REQUIRED INFORMATION OR PLACE LABELS ON ALL THREE COPIES

☐ EH ☐ FP ☐ MTY/PN ☐ NOD ☐ STD ☐ TB ☐ CD ☐ COR

Health Care Provider
Address
City County
State Zip Code
Contact Name:
Phone# Fax#
Test Request Authorized by:

Patient SS# (last 4 digits):
Last Name ☐ SR ☐ JR ☐ Other
First Name M.I.
Date of Birth (mm/dd/yyyy) / /
Address
City County
State Zip Code

Sex: ☐ Male ☐ Female ☐ Transgender M to F ☐ Transgender F to M
Ethnicity: Hispanic or Latino Origin? ☐ yes ☐ no
Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/other Pacific Islander ☐ White

MRN/Case # DOC # Outbreak # Submitter Lab #
Date Collected: Time Collected: ☐am ☐pm Onset Date:
Reason for Test: ☐ Screening ☐ Diagnosis ☐ Contact ☐ Test of Cure ☐ 2-3 Months Post Rx ☐ Suspected Carrier ☐ Isolate for ID ☐ Release
Therapy/Drug Treatment: ☐ No ☐ Yes Therapy/Drug Type: Therapy/Drug Date:

SPECIMEN SOURCE CODE

BACTERIOLOGY
Bacterial Culture - Routine
Additional specimen codes:
Bordetella pertussis
Group A Strep
Group B Strep Screen
C. difficile Toxin
Diphtheria
Foodborne Pathogens (*B. cereus, C. perfringens, S. aureus*)
Gonorrhea Culture:Incubated? ☐ yes ☐ no
Hrs. incubated: Add'l specimen codes:
MRSA (rule out)
VRE (rule out)
ENTERIC INFECTIONS
Campylobacter
E. coli 0157 typing/Shiga toxins
ABC'S (BIDS) #
Organism:
Bacteria Referred Culture for ID

SPECIMEN SOURCE CODE

MYCOBACTERIOLOGY/AFB/TB
AFB/TB Culture and Smear
AFB/TB Referred isolate for ID
M. tuberculosis Referred Culture for Genotyping
Nucleic Acid Amplification Test for *M. tuberculosis* Complex (GeneXpert)
PARASITOLOGY
Blood Parasites:
Country visited outside US:
Ova & Parasites: Immigrant? ☐yes ☐no
Cryptosporidum
Cyclospora/Isospora
Microsporidium
Pinworm
VIRUS ISOLATION/CHLAMYDIA
Adenovirus*
Chlamydia trachomatis culture
Cytomegalovirus (CMV)
Enterovirus (Inc. Echo & Coxsackie)
Herpes Simplex Virus (Types 1 & 2)
Influenza (Types A & B)* Rapid Flu Test:
Type
Result: ☐ Negative ☐ Positive
Patient admitted to hospital? ☐ yes
Parainfluenza (Types 1, 2, & 3)*
Respiratory Syncytial Virus (RSV)*
Varicella (VZV)

SPECIMEN SOURCE CODE

SPECIAL BACTERIOLOGY
Legionella Culture
Leptospira
Mycoplasma (Outbreak Investigation Only)
RESTRICTED TESTS
Pre-approved submitters only
Chlamydia trachomatis/GC NAAT
Norovirus ** (see comment on back)
QuantiFERON
OTHER TESTS FOR INFECTIOUS AGENTS
Test name:
Prior arrangements have been made with the following DHMH Laboratories Administration employee:

SPECIMEN SOURCE CODE
PLACE CODE IN BOX NEXT

B	Blood
BW	Bronchial Washing
CSF	Cerebrospinal Fluid
CX	Cervix/Endocervix
E	Eye
F	Feces
N	Nasopharynx/Nasal
P	Penis
R	Rectum
SP	Sputum
T	Throat
URE	Urethra
UFV	Urine (First Void)
UCC	Urine (Clean Catch)
V	Vagina
W	Wound
O	Other:

SPECIMEN SOURCE (must be completed)
Test Requested: CT/GC NAAT
20CT15980
Valid 01/01/2020 to 12/31/2020 Maryland

Original

Questions? Please call the Chlamydia lab at (443) 681-3937 (Sarah Langtry, Supervisor).