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.

Please do not affix labels over data fields or in the box marked "Accession Number Barcode (For SPHL use only)". If a label needs to be put on the form, please put it in the Remarks box.

An Immunology Test Request Form is required for each CT/GC specimen submitted to the MSPHL. 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.

Test Requested/Specimen Type Section

- **Syphilis Testing:** Mark the appropriate check box: Serum/Blood; or CSF (cerebrospinal fluid).
- **Syphilis:** Mark the appropriate check box only if applicable; Suspected Latent; or Previous Reactive.
- **HIV Testing:** Mark the appropriate check box: Serum/Blood; or Plasma.
- **HIV Rapid Testing:** Mark the Preliminary Positive box only if applicable. This box only applies to sites performing rapid HIV testing.
- **Chlamydia/Gonorrhea Testing:** Mark the appropriate check box: Endocervical swab; Vaginal swab; Urethral swab; Rectal swab; Urine; or Pharyngeal swab
- **Date Specimen Collected:** Complete in the format of mm/dd/yyyy (i.e. February 8, 2021 = 02/08/2021). Date Specimen Collected must be recorded on the specimen tube.
- **Client Reference:** Optional field. This is a searchable field in the Web Portal.

Patient Information Section

- **Last Name; First Name:** The name on the form **must** be identical to the name on the specimen tube or the specimen may be considered unsatisfactory for testing and not tested.
- **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.
- **Address; City; State; Zip Code:** Complete fully
- **Current Gender Identity:** Check the box for the current identified gender of the patient: Female; Male; or Other
- **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.

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, telephone number and full address.

Submitter Information Section

- **Facility Name; Address; City; State; Zip Code:** Results will be returned to this address. If accessing this form electronically from the MSPHL website the Facility Name, Address, City, State and Zip Code will auto-populate.
- **Submitter Contact Name and Submitter Telephone Number:** must be entered manually on the form.

NOTE: If there is no Submitter listed on the form, 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.

- **Outreach Event:** Optional field

Additional Patient Information and Patient History

- **Sex Assigned at Birth:** Check the appropriate box.
- **Medical Record/Chart:** Optional field.
- **Medicaid Number/DCN:** Record the patient's Medicaid number (DCN number) if available(The MSPHL does not currently collect re-imbursement from other/private insurance providers.)
- **Patient's County of Residence:** Record the patient's county of residence.
- **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** ≥ 2 partners(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.