



AR Lab Network *Neisseria gonorrhoeae* Etest
Utah Public Health Laboratory
4431 South 2700 West
Taylorsville, Utah 84129
ARLNutah@utah.gov



| PATIENT INFORMATION | | | | SPECIMEN INFORMATION | | | |
|--|----------|--|---------------------|---|----------------|--|-------------------|
| LAST NAME | | | | DATE COLLECTED (mm/dd/yyyy) | TIME COLLECTED | <input type="checkbox"/> AM <input type="checkbox"/> PM | DATE SENT TO ARLN |
| FIRST NAME | | MIDDLE INITIAL | DATE OF BIRTH (DOB) | SPECIMEN TYPE: Please only select one <input type="checkbox"/> Isolate <input type="checkbox"/> Swab <input type="checkbox"/> Other (specify) _____ | | | |
| MEDICAL RECORD #/ PATIENT ID | | PHL ISOLATE OR SPECIMEN ID | | SPECIMEN SOURCE: Please select ONE source option below. | | | |
| GENDER <input type="checkbox"/> MALE <input type="checkbox"/> UNKNOWN | | <input type="checkbox"/> FEMALE <input type="checkbox"/> UNSPECIFIED | | <input type="checkbox"/> BLOOD <input type="checkbox"/> URETHRAL | | <input type="checkbox"/> CONJUNCTIVAL <input type="checkbox"/> URINE | |
| <input type="checkbox"/> ENDOCERVICAL | | <input type="checkbox"/> PHARYNGEAL | | <input type="checkbox"/> SYNOVIAL FLUID | | <input type="checkbox"/> VAGINAL | |
| <input type="checkbox"/> RECTAL | | <input type="checkbox"/> OTHER(specify) | | | | | |
| STREET ADDRESS | | CITY | | TEST REQUESTED (pre-approval required) | | | |
| STATE/TERRITORY | ZIP CODE | COUNTY/BOROUGH /VILLAGE | | <input type="checkbox"/> Gradient Strip <i>Neisseria gonorrhoeae</i> Antimicrobial Susceptibility Testing | | | |
| PATIENT TRAVEL INFORMATION In the previous 30 days prior to sample collection did the patient travel (international or interstate)? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN | | | | REASON FOR TEST REQUEST <input type="checkbox"/> Treatment failure <input type="checkbox"/> Other (please specify): _____ | | | |
| If yes, please specify the most recent travel <input type="checkbox"/> Interstate (please specify location): _____ <input type="checkbox"/> International (please specify location): _____ | | | | TEST APPROVAL | | | |
| | | | | Pre-approval is required for testing. Specimens without prior approval will not be tested. Has this testing request been approved by AR Lab Network staff? <input type="checkbox"/> NO <input type="checkbox"/> YES (please specify name of staff below) | | | |
| | | | | NAME OF APPROVING AR LAB NETWORK STAFF | | DATE APPROVED | |
| SUBMITTER INFORMATION | | | | PROVIDER CODE: | | | |
| SUBMITTING FACILITY NAME | | | | NAME OF ORDERING PROVIDER | | | |
| FACILITY ADDRESS | | | | | | | |
| PHONE NUMBER | | | | EMAIL/SECURE FAX NUMBER | | | |
| CITY | | STATE/TERRITORY | ZIP CODE | COUNTY | | | |
| GENERAL SHIPPING INSTRUCTIONS | | | | | | | |
| <ul style="list-style-type: none"> • Please print legibly and complete <u>all fields</u>. • Each specimen must be clearly marked with two unique patient identifiers that exactly match this form. • Please contact ARLNutah@utah.gov or (801)965-2400 for testing approval and questions • All shipped specimens must meet Department of Transportation and International Air Transport Association regulations. It is the shipper's responsibility to ensure all regulations are met. • Ship to: Utah Public Health Laboratory Attn: ARLN 4431 South 2700 West Taylorsville Utah 84129 | | | | | | | |