Form 194
Revised 9/2018

"This form, when filled in, contains patient information that must be protected in accordance with the Health Insurance Portability & Accountability Act."

KY Division of Laboratory Services
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Frankfort, Kentucky 40601
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Kentucky Public Health
Prevent. Promote. Protect.

CHLAMYDIA TRACHOMATIS and NEISSERIA GONORRHOEAE

PATIENT INFORMATION:

Name (Last, First, MI) _____ *(Codes defined on second page)*

Social Security # Sex Age DOB Race/Ethnicity *(circle one)* 1 2 4 5 6 7

Home Address _____

City State Zip Code County

Send Report To:

Health Department _____

Street Address (PO BOX) _____

City State Zip Code

Please use "L" label or fill in completely

Reason For Testing: Did the patient present with Chlamydia/GC symptoms? ☐ Yes ☐ No
Is the patient pregnant? ☐ Yes ☐ No ☐ Unknown

Mark one:
- ☐ Volunteer/Medical Problem
- ☐ Initial (Fam. Plan.) Visit
- ☐ Revisit/Annual (Fam. Plan.)
- ☐ Prenatal Visit
- ☐ Sex Partner Referral
- ☐ Other, please specify_____
- ☐ Unknown/Undetermined_____
- ☐ Cancer

Specimen Information: Source (mark one): ☐ Cervical ☐ Urine ☐ Urethral ☐ Other, specify_____

Date of Collection _____ (dd-mmm-yy) Kit Exp. Date _____ (dd-mmm-yy)

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Laboratory Results

Chlamydia trachomatis	Neisseria gonorrhoeae	Unsatisfactory
☐ Negative	☐ Negative	☐ No Specimen Received
☐ Positive	☐ Positive	☐ Improper Swabs
☐ Equivocal (submit another specimen)	☐ Equivocal (submit another specimen)	☐ Transport Media Expired
		☐ Other_____

Date and Time Received: **Laboratory Number:**

Date Reported: **Technologist:**