



LOS ANGELES COUNTY STD PROGRAM CHLAMYDIA & GONORRHEA LABORATORY REPORT



DATE OF REPORT

REPORT STATUS New Update

REPORT DONE BY

1 PATIENT
 2 PROVIDER
 3 LABORATOR
 4 REFERENCE LAB
 5 TEST RESULT

1 PATIENT

PATIENT'S LAST NAME FIRST NAME M.I.

PATIENT'S STREET ADDRESS APT/UNIT NO.

CITY/TOWN STATE ZIP CODE

AREA CODE - DAY TELEPHONE NUMBER - GENDER: Male Female Transgender (M to F) Transgender (F to M) Unknown or Refused

AREA CODE - EVENING TELEPHONE NUMBER - PREGNANT: Yes No Unknown

POSTPARTUM: Yes No Unknown

Birth Date - - AGE:

RACE (X all that apply): White Black or African American Native American or Alaska Native Asian or Asian American Native Hawaiian or Pacific Islander Unknown Refused Other:

2 PROVIDER

DOCTOR'S LAST NAME DOCTOR'S FIRST NAME M.I.

FACILITY/CLINIC NAME

FACILITY STREET ADDRESS SUITE/UNIT NO.

CITY/TOWN STATE ZIP CODE

AREA CODE - TELEPHONE NUMBER - AREA CODE - FAX NUMBER -

For HIV REPORTING:
Call (213) 351-8516 or visit publichealth.lacounty.gov/hiv/

3 LABORATOR

LABORATORY'S NAME

LABORATORY'S STREET ADDRESS

CITY/TOWN STATE ZIP CODE

AREA CODE - TELEPHONE NUMBER - AREA CODE - FAX NUMBER -

4 REFERENCE LAB

REFERENCE LABORATORY'S NAME (If specimen was sent for further testing from original lab to reference lab, reference lab info required in addition to the above information)

REFERENCE LABORATORY'S STREET ADDRESS

CITY/TOWN STATE ZIP CODE Test Date (MM-DD-YY): - -

AREA CODE - TELEPHONE NUMBER - AREA CODE - FAX NUMBER - Date reported (MM-DD-YY): - -

5 CHLAMYDIA

TEST NAME

TEST RESULT

SPECIMEN TYPE

SPECIMEN SITE: Urine Vaginal Other

Cervix Rectum

Urethra Nasopharynx

Spec. Coll. Date (MM-DD-YY): - -

Test Date (MM-DD-YY): - -

Specimen ID #:

Date reported (MM-DD-YY): - -

GONORRHEA

TEST NAME

TEST RESULT

SPECIMEN TYPE

SPECIMEN SITE: Urine Vaginal Other

Cervix Rectum

Urethra Nasopharynx

Spec. Coll. Date (MM-DD-YY): - -

Test Date (MM-DD-YY): - -

Specimen ID #:

Date reported (MM-DD-YY): - -