



# LOS ANGELES COUNTY STD PROGRAM CHLAMYDIA & GONORRHEA LABORATORY REPORT



DATE OF REPORT  -  -

REPORT BY

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

**1 PATIENT**

PATIENT'S LAST NAME  FIRST NAME  M.I.

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  Unknown  No

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:

POSTPARTUM:  Yes  Unknown  No

**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/](http://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

AREA CODE  TELEPHONE NUMBER  -  AREA CODE  FAX NUMBER  -

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

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 #:

COMMENTS:

**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 #:

COMMENTS: