WV DHHR- Office of Laboratory Services
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South Charleston, WV 25303
Phone (304)558-3530 FAX (304) 558-2006

Instructions for the Collection, Submission Form and Mailing Of Chlamydia/Gonorrhea Urine Specimens

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The Office of Laboratory Services provides the following testing supplies:

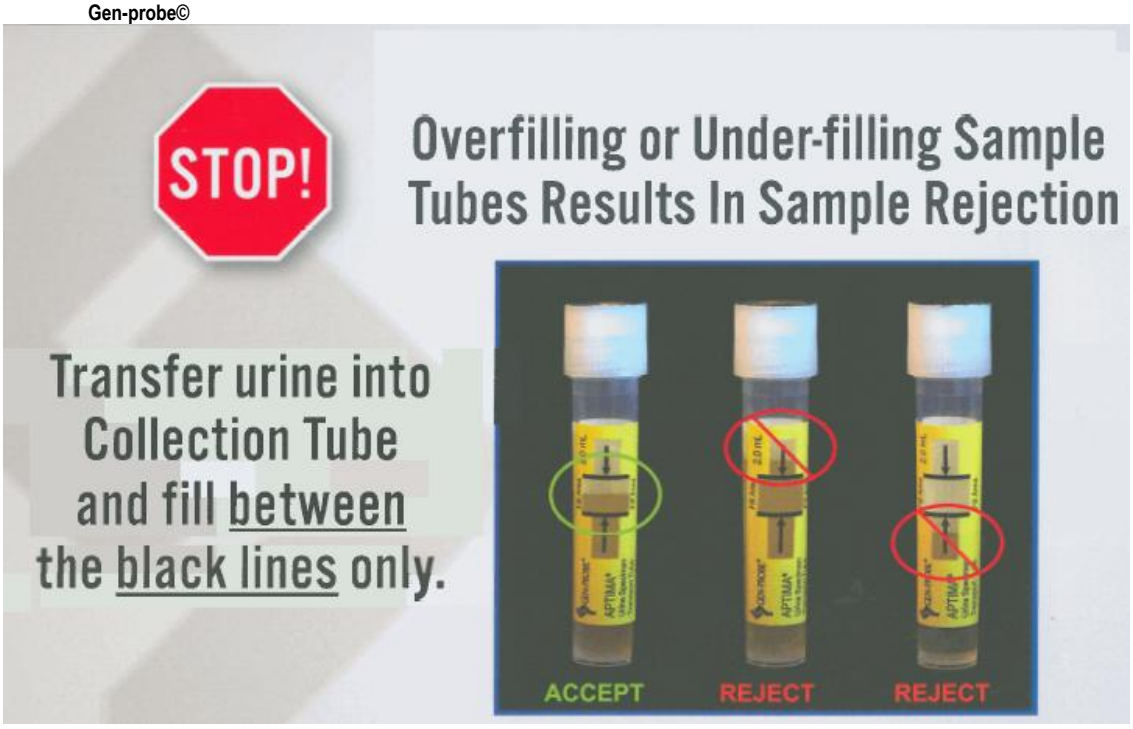
1. GenProbe urine specimen transport tube
2. Plastic transfer pipette
3. Specimen collection cup
4. Collection cup lids (when requested by provider)
5. Providers can access the "**REQUISITION FORM FOR SPECIMEN MAILING KITS"** form at the OLS website **www.wvdhhr.org/labservices.**

Urine Specimen Collecting Instructions:

1. The patient should not have urinated for at least 1 hour prior to specimen collection.
2. Female patients should not cleanse the labial area prior to providing the specimen.
3. Direct the patient to provide first-catch urine into a urine collection cup free of any preservatives.
4. The clinician should remove the cap from the 'urine specimen transport tube' and transfer 2 mL of urine from the urine cup into the 'urine specimen transport tube' using the disposable pipette provided.
5. When the fluid level is between the black fill lines on the 'urine specimen transport tube' label, the correct volume of urine has been added.
6. Re-cap the urine specimen transport tube tightly.
7. Place patient's name and draw date on the collection tube.
8. Send specimens to the lab immediately after collection to insure best results.

NOTE: Badly hemolyzed or bacterially contaminated urine, produces unreliable results.
NOTE: Sites using labels should not cover the side of the tube that shows the urine level.

Gen-probe©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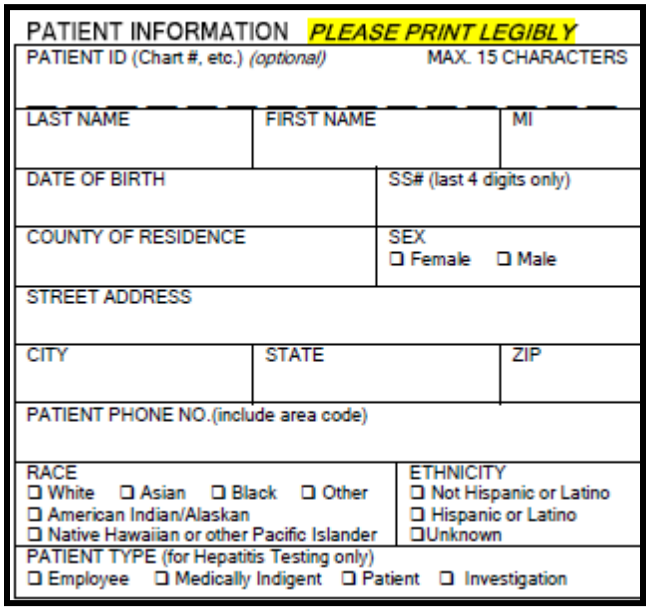
Form Instructions:

The form can be accessed on the OLS website. www.wvdhhr.org/labservices.

1. **Please print legibly**. Complete the form using blue or black ink.
2. The Clinical Laboratory Improvement Amendments (CLIA) requires:
   a. **A unique identifier on both the form and the specimen (usually first and last name)**
   b. **Address of Submitter**
   c. **Date of Birth or Age of Patient**
   d. **Gender of Patient**
   e. **The Test to be Performed**
   f. **The Source of the Specimen- Urine**
   g. **Date of Collection**
   h. **Any Additional Information relevant to testing(i.e. information necessary by the program)**



PATIENT INFORMATION *PLEASE PRINT LEGIBLY*

PATIENT ID (Chart #, etc.) *(optional)* MAX. 15 CHARACTERS

LAST NAME	FIRST NAME	MI

DATE OF BIRTH	SS# (last 4 digits only)

COUNTY OF RESIDENCE	SEX ❑ Female ❑ Male

STREET ADDRESS

CITY	STATE	ZIP

PATIENT PHONE NO.(include area code)

RACE	ETHNICITY
❑ White ❑ Asian ❑ Black ❑ Other ❑ American Indian/Alaskan ❑ Native Hawaiian or other Pacific Islander	❑ Not Hispanic or Latino ❑ Hispanic or Latino ❑Unknown

PATIENT TYPE (for Hepatitis Testing only)
❑ Employee ❑ Medically Indigent ❑ Patient ❑ Investigation

3. The instructions indicate if the information is Optional, CLIA required or Program required.

Patient Information:

a. **Patient ID** – This refers to a chart number or some other internal ID that your facility uses to identify patients. A maximum of 15 characters is allowed. (Optional)

b. **Last Name, First Name, MI** – Patients full name. (unique identifier required by CLIA)

c. **Date of Birth** – (Required by CLIA)

d. **Social Security Number** – last 4 digits only (Optional)

e. **County of Residence** – The patient's county of residence is not always the same as the provider's county. (Required by Program)

f. **Sex –** (Required by CLIA)

g. **Street Address, City, State, Zip Code**- (Required by program)

h. **Patient Phone Number(include area code)**- (Required by program)

i. **Race** – More than one can be marked (Required by program)

j. **Ethnicity** – (Required by program)

k. **Patient Type** – Only if ordering Hepatitis Tests(Required by OLS)

Submitter Information:

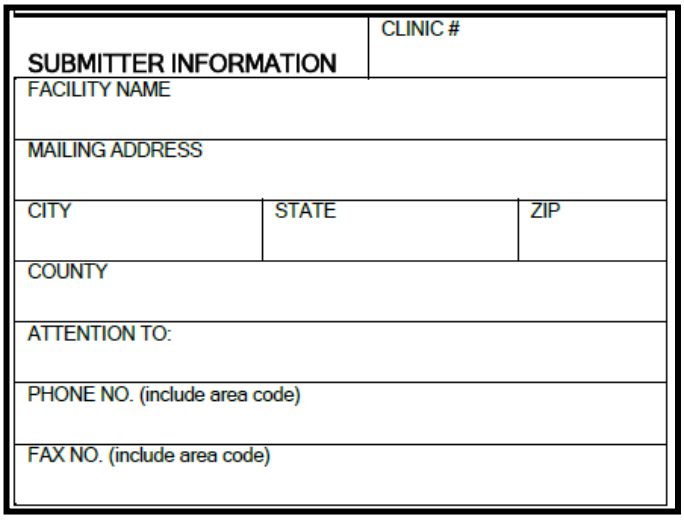
a. **Clinic Number**- This refers to the clinic number that is assigned by the program. The Family Planning clinic number is usually 10 digits or the letters FP appear in it. (Optional) The STD program does not currently have clinic numbers.

b. **Facility Name** – The official name of the site as listed on the MOU. Do not use the initials of your site. (*Required by CLIA)*

c. **Street Address, City, State, Zip Code-** (*Required by CLIA)*

d. **County-** *(Required by Program)*

e. **Attention To:** - This line is to be filled out if the results are to go to a specific individual or department within the facility. *(Optional)*



SUBMITTER INFORMATION CLINIC #

FACILITY NAME

MAILING ADDRESS

CITY	STATE	ZIP

COUNTY

ATTENTION TO:

PHONE NO. (include area code)

FAX NO. (include area code)

f. **Phone Number and Fax Number (Include area code)** – *(Required by Program)*

DATE OF COLLECTION:	
CLINIC TYPE (Select ONE Only):	
❑ APC	❑ Jail / Prison
❑ CBO	❑ Juvenile Detention Center
❑ College / University -FP	❑ Project # _____
❑ College / University -STD	❑ STD Clinic/STD Services
❑ Family Planning	❑ Substance Abuse Center
❑ Hospital	❑ TB Clinic
TEST REQUESTED (Select ONE Only):	
❑ Hepatitis A IgM (Approval required from Program)	❑ Rubella Screen ❑ Syphilis Screen (RPR)
❑ Hepatitis B Screen	❑ CT/GC Amplified (urine) / NAAT
❑ Hepatitis C Antibody	❑ HIV
❑ Hepatitis Post-Vac (HBsAb) **FEE FOR SERVICE**	❑ Orasure WB **(for Rapid HIV Program Only)**
SOURCE OF SPECIMEN:	
❑ Blood / Serum	❑ Urine
❑ Oral fluid	

Other Information:

a. **Date of Collection – (Required by CLIA)**

b. **Site/Clinic Type – (Required by the Program)** Mark the type of Clinic at which the patient is being seen. Providers unsure of clinic type should contact program representatives for more information.

1. HIV/AIDS and STD Program (HADS)- 304-558-2195
2. Family Planning Program- 304-558-5388

c. **Test Requested - CT/GC Amplified (urine)/NAAT (Required by CLIA)**

d. **Source of Specimen** Mark Urine.

CT/GC Information-Reason for Test

Under the current guidelines FP females under the age of 26 and FP males under the age of 30 can be routinely screened for Chlamydia and Gonorrhea at approved Family Planning Clinics.

CT/GC INFORMATION - REASON FOR TEST (as per guidelines)	
❑ Any symptom of STD	❑ Re-screen of previous positive
❑ Known contact to STD	❑ Suspect contact to STD
❑ IUD Insertion	

NOTE: Females Over 25 and Males over 30 can still qualify for DIAGNOSTIC TESTING

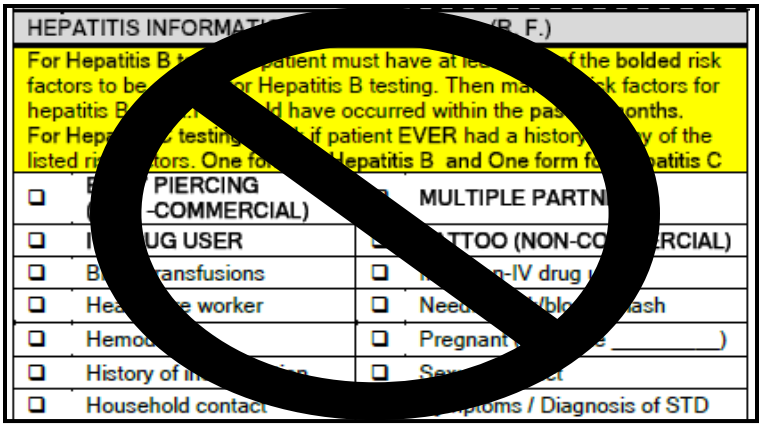
a. Clinician must mark the reason for requesting the test.
   1. Any symptom of STD
   2. Known contact to STD
   3. Re-screen of previous +- If known indicate date of previous test
   4. Suspected contact to STD
   5. IUD insertion

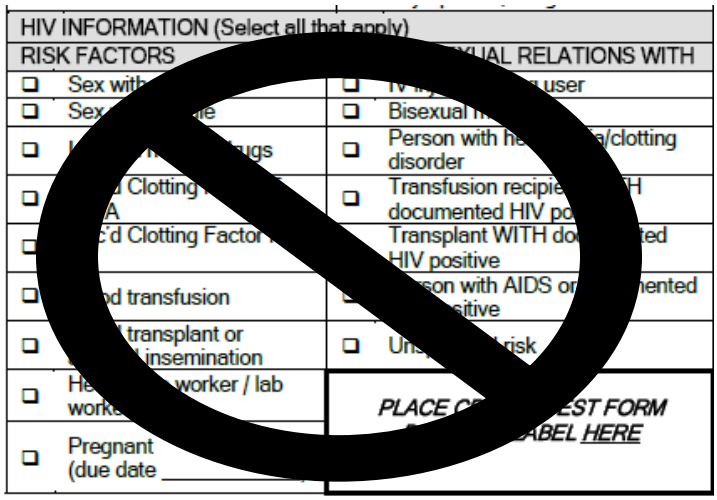
b. **If no reason is indicated the specimen will be marked as unsatisfactory and the test will not be preformed.**

Risk Factors

1. Hepatitis INFORMATION –

NOTE: THIS SECTION DOES NOT NEED TO BE FILLED OUT WHEN REQUESTING CT/GC TESTING.





2. HIV INFORMATION(Select all that apply)–

NOTE: THE HIV INFORMATION SECTION DOES NOT NEED TO BE FILLED OUT WHEN REQUESTING CT/GC TESTING

Mailing Instructions: *Packaging provided by OLS meets all current DOT and Postal Regulations*

PREPARE SPECIMEN(S) FOR MAILING

Using mailing tubes:

- **a.** Place urine collection device in the inner plastic container (maximum 8 devices per container).
- **b.** Place 2 absorbent pads in the inner plastic container with the collection devices.
- **c.** Screw lid on plastic container.
- **d.** Fold the DI requisition form in half, length- wise and wrap forms around plastic container.
- **e.** Place inner container and forms into outer container, apply postage or UPS labels, and mail.
- **f.** Urine collection devices can be placed in the same container as blood tubes
- **g.** **Note: If your site is sending less than 8 tubes and concerned about the tubes 'rattling' around in the container, add some additional padding such as a paper towel to the inner container.**

Rev06/11dlm