State of New Jersey Department of Health
Public Health and Environmental Laboratories
3 Schwarzkopf Drive, Ewing, NJ 08628
https://www.nj.gov/health/phel/

SEXUALLY TRANSMITTED DISEASE REQUISITION FORM

Patient Information

Name (Last, First, MI)	Sex for Clinical Purposes: Male / Female / Unknown	Chart ID#

Street Address	City	Zip Code	Sexual Orientation

Ethnicity	Race	Gender Identity

Collection Date	Collection Time

Test Order Choice

- C. trachomatis & N. gonorrhoeae Combination NAAT (40003)
- Chlamydia trachomatis NAAT (40001)
- Neisseria gonorrhoeae NAAT (40002)
- GC Culture (GON)
- Routine Syphilis Serology (30001)
- Confirmatory Syphilis Panel (30002)

Syphilis

Previous Positive

Yes No Unknown

If Yes - Date of Previous Positive

Reason for Visit/Test

Routine Screen	Contact
Employment	Suspicious Lesion
Prenatal	Suspicious Rash
Follow Up	Suspect Primary Syphilis
No Reason Given	Suspect Congenital Syphilis

NAAT / Culture

Site Collected

Cervical	Rectal
Male Urethral	Urine
Vaginal	
Oral	

Reason for Visit/Test

Routine Screen	Contraceptive Service
Symptomatic	TOC
Contact to STD	Other
Pregnancy Test	No Reason Given
Prenatal	

For Lab Use Only

Date/Time Received

Lab/Sample ID#

Remarks

Clinic Information

Facility Name	Code/Site No.

Address Line 1	Address Line 2

City	State	Zip Code

INSTRUCTIONS FOR COMPLETING THE "SEXUALLY TRANSMITTED DISEASE REQUISITION FORM"

Before completing and submitting the form, please read the following directions carefully. Failure to follow these directions could result in the delay or rejection of the specimen.

For All Test Requests:

1. Complete a separate form for each specimen.
2. Provide all information requested on the form.
3. Specimens should be labeled with two (2) identifiers (e.g., patient name, date of birth, other unique patient ID).
4. Should you need additional space, please submit a separate sheet of paper that includes patient name and date of birth.
5. Specimen and STD-1 identifiers must match EXACTLY.
6. Specimens may be rejected, and testing will be delayed if information is missing, incomplete, or inaccurate.
7. Please include a copy of any available laboratory test results

If completing a printed copy of this form, please use the following legend to fill in the "Patient Information" section. Please write the option exactly as it appears below:

Sexual Orientation

Lesbian
Gay
Straight
Bisexual
Unknown
Decline to answer
Something Else

Gender Identity

Male
Female
Transgender Male (TM)/Female to Male
Transgender Female (TF)/Male to Female
Genderqueer/Non-Binary
Decline to Answer
Other

Ethnicity

Hispanic or Latino
Not Hispanic
Unknown

Race

American Indian or Alaskan Native
Asian
Black or African American
Native Hawaiian or Other Pacific
Islander White
Other Race