

Specimen Collection and Submission Guidance for *Chlamydia trachomatis* and *Neisseria gonorrhoeae* Screening (by Amplified RNA Probe)

Collect each specimen using the appropriate collection and transport kit.
Follow the manufacturer's (Hologic®) specimen collection instructions.

Vaginal, Rectal, and Throat Swabs

Use: Aptima® Multitest Swab Specimen Collection and Transport Kit

Specimen Storage and Shipping

Vaginal Swabs: After collection, store and ship swabs in specimen transport tube at 2°C to 30°C.

Rectal and Throat Swabs: After collection, store and ship swabs in specimen transport tube at 4°C to 30°C.

- **Swabs must be received within 58 days of collection.**
- **Freeze vaginal swabs at -20 °C to -70 °C within 7 days of collection for long-term storage.**



Aptima® Multitest Swab Specimen Collection and Transport Kit

Urine Specimens

Use: Aptima® Urine Specimen Collection and Transport Kit

Specimen Storage and Shipping

Transfer urine sample to Aptima® urine specimen transport tube within 24 hours of collection.

Store and ship transport tubes at 2°C to 30°C.

- **Specimens must be received within 28 days of collection.**
- **Freeze at -20 °C to -70 °C within 7 days of collection for long-term storage.**



Aptima® Urine Collection and Transport Kit

Endocervical and Urethral Swabs

Use: Aptima® Unisex Swab Specimen Collection and Transport Kit

Specimen Storage and Shipping

After collection, store and ship swabs in specimen transport tube at 2°C to 30°C.

- **Swabs must be received within 58 days of collection.**
- **Freeze at -20 °C to -70 °C within 7 days of collection for long-term storage.**



Aptima® Unisex Swab Specimen Collection and Transport Kit

Specimen Collection and Submission Guidance for Testing of *C. trachomatis* (CT) and *N. gonorrhoeae* (GC) by Amplified RNA Probe

Ensure Specimen Labels Have at Least Two Unique Identifiers

Three unique patient identifiers on specimen are preferred.



Three patient identifiers provided on this label.

1. Name
2. Date of Birth
3. Medical Record Number

Provide Patient Identifiers in Sections 2 and 3 of Form G-2B

Patient identifiers on specimen label and G-2B form must match exactly.

Date of Collection must be provided in Section 3.

SECTION 2. PATIENT				
NOTE: Patient name on specimen MUST match name on this form exactly. Name mismatches will be rejected. e.g., Partial name on specimen label but full name on specimen container must have two (2) unique identifiers that match this form.				
** REQUIRED	Last Name **		First Name **	
	Snow		John	
	Address **			
	39 Broad Street			
	City **	State **	Zip Code **	
	Austin	TX	78756	
DOB (mm/dd/yyyy)	Sex **	Ethnicity:		
3/15/2001	M			
Race: <input type="checkbox"/> White <input type="checkbox"/> American Indian / Native Alaskan <input type="checkbox"/> Asian				
SECTION 3. SPECIMEN				
NOTE: If the 'Date of Collection' field is not completed, the specimen will be rejected.				
ED	Date of Collection (mm/dd/yyyy) **		Time of Collection **	Collected
	2/21/2024		<input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	
	Unique Identification Number ** e.g., MRN / Alien # / Accession #		Comments or Additional ID: e.g., CDC ID, Previous DSHS Specimen Label	
06161858				

Request Test in Section 4.2

Select "GC/CT, amplified RNA probe".

4.2 Bacteriology	
Clinical Specimen	Definitive Identification
<input type="checkbox"/> Aerobic Isolation <input type="checkbox"/> Anaerobic Isolation <input type="checkbox"/> Culture, stool <input type="checkbox"/> Diphtheria Screen <input checked="" type="checkbox"/> GC/CT, amplified RNA probe <input type="checkbox"/> Haemophilus spp. Isolation	<input type="checkbox"/> Anaerobic identification <input type="checkbox"/> Organism Susceptibility <input type="checkbox"/> Bacillus spp. <input type="checkbox"/> Campylobacter <input type="checkbox"/> Enteric bacteriology <input type="checkbox"/> Gram Negative

Select the Payor in Section 6

Check the appropriate box as Payor. If left empty, the submitter is charged.

** REQUIRED	<input type="checkbox"/> Medicaid (2) <input type="checkbox"/> Medicare (8) Medicaid/Medicare #: _____
	<input type="checkbox"/> Submitter (3) <input type="checkbox"/> Immunizations (1609) <input type="checkbox"/> BIDS (1720) <input type="checkbox"/> Private Insurance* (4) <input type="checkbox"/> BT Grant (1719) <input type="checkbox"/> TIPP (5144) <input type="checkbox"/> HIV / STD (1608) <input type="checkbox"/> Zoonosis (1620) <input type="checkbox"/> IDEAS (1610) <input type="checkbox"/> Other: _____

Identify Specimen Type in Section 3

Select only one specimen source.

Questions About . . .

Specimen Collection/Suitability:

(512) 776-7657 or 512-776-2449

Specimen Shipping:

(512) 776-7598 or 1-888-963-7111 ext. 7578 (toll free)

Supply Ordering:

(512) 776-7661 or ContainerPrepGroup@dshs.texas.gov

Submitter Accounts, Submission Forms, or Result Reports: (512) 776-7578 or LabInfo@dshs.texas.gov



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