***Neisseria gonorrhoeae* Gradient Strip AST Authorization Form**

Instructions: Please provide the following information and submit the completed form via email to mdphl.arln@maryland.gov with subject line "**GC Etest Request**." If the request is approved, additional guidance will be provided for specimen submission.

As indicated by my submission, I acknowledge the following by checking the boxes below:

- ☐ The patient providing this sample has been clinically evaluated and reinfection has been deemed to be less likely than a GC treatment failure in this case.
- ☐ This sample is being submitted for AST due to my active consideration of GC treatment failure.
- ☐ I am aware that de-identified AST results and selected isolates will be shared with CDC for public health response purposes.

Patient/Isolate Information

Patient Initials: _____ Patient date of birth:_____

Specimen collection date:_____ Specimen source:_____

Check one: ☐ Clinical Specimen ☐ Isolate

Specimen ID# (submitting facility ID or accession number):_____

Submitter Contact Information – All information must be provided.

Test Request Date: _____ Ordering Provider: _____

Healthcare Facility Name and Address:_____

Type of facility: ☐ Public health department ☐ hospital/emergency department ☐ physician's office ☐ STD clinic ☐ other _____

Point of Contact Name:_____ Phone Number:_____

Fax Number:_____ Email: _____

Results will be returned by secure fax and encrypted email.