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## **CONSENT FOR CHLAMYDIA & GONORRHEA LAB TEST**

**Annual screening for Chlamydia and Gonorrhea are recommended to all sexually active women age 25 and younger, as well as other asymptomatic women at high risk for infection.**

According to the National Center for Health Statistics (NCHS), chlamydia remains the most commonly reported STD in the US. In 2005, there were just over 976,000 reported chlamydial infections, but because many cases are not diagnosed or reported, there may be as many as 2.8 million new cases annually. About 75% of chlamydial infections in women don't produce symptoms or if they do, they are often vague, causing women to delay seeking medical care and treatment. If not treated, up to 40% of women infected with chlamydia may develop pelvic inflammatory disease (PID), which can lead to ectopic pregnancy and infertility. One in five women with PID becomes infertile.

Chlamydia is caused by bacteria and is passed from person to person through sex, as is gonorrhea, another bacterial STD. Both chlamydia and gonorrhea infect the same sites in a woman's reproductive tract and are often diagnosed and treated together.

Gonorrhea is a bacterial infection of the urethra in men and the urethra, cervix, or both in women. Gonorrhea can also infect the rectum, anus, throat, pelvic organs, and, in rare cases, the conjunctiva, which is the membrane that lines the eyelid and eye surface. It is fairly common for gonorrhea to cause no symptoms, especially in women. People who do not have symptoms can unknowingly transmit gonorrhea infections to their sex partners.

Lab tests must be done to confirm chlamydia and gonorrhea infection.

*I, \_\_\_\_\_ I have received information regarding Chlamydia and Gonorrhea. I understand that Lab tests must be done to confirm chlamydia and gonorrhea infection. I also understand that additional charges will be made by the laboratory due to such test and I will be responsible for payment (If health insurance is available, the laboratory will bill my insurance first and I will be responsible for any payment not covered by my insurance).*

- I am \_\_\_\_\_ years old and I authorize Castillo Walters OB/GYN to perform the test for Chlamydia and Gonorrhea.*
- I am \_\_\_\_\_ years old and I DO NOT authorize Castillo Walters OB/GYN to perform the test for Chlamydia and Gonorrhea.*

\_\_\_\_\_  
*Patient signature / Legal Guardian*

\_\_\_\_\_  
*Date*