



# Communicable Diseases Laboratory Test Requisition

Laboratory Specimen Number  
(FOR PUBLIC HEALTH USE ONLY)

Authorization Code: \_\_\_\_\_  
(if applicable)

**REQUISITION MUST BE FILLED OUT COMPLETELY**

Type or use indelible dark ink and print legibly with capital letters

Outbreak #: \_\_\_\_\_

**SUBMITTER INFORMATION:**

Submitting Institution \_\_\_\_\_

Submitter Address (Street Number, Name of Street) \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

ZIP Code \_\_\_\_\_

Contact Person/Clinician's Last Name \_\_\_\_\_

Telephone Number \_\_\_\_\_

FAX \_\_\_\_\_

E-mail Address \_\_\_\_\_

**PATIENT INFORMATION:**

Patient's Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Middle Name \_\_\_\_\_

Street Address \_\_\_\_\_

Apartment/Suite Number \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

ZIP Code \_\_\_\_\_

Telephone Number \_\_\_\_\_

Birthdate (mm/dd/yyyy) \_\_\_\_\_

Age \_\_\_\_\_

**Sex**

- Male
- Female

**Race**

- White
- African American/ Black
- Native American
- Asian/Pacific Islander
- Other/Unknown

**Ethnicity**

- Hispanic
- Non-Hispanic

Patient ID # (optional) \_\_\_\_\_ Medicaid Recipient ID # \_\_\_\_\_

**TEST REQUEST INFORMATION** When sending acute and convalescent serology specimens, use one test requisition. Complete collection information immediately below for acute specimen and complete collection information for convalescent specimen in the "Source/Specimen Type" box.

Date Collected (mm/dd/yyyy) \_\_\_\_\_ Time collected ( ) a.m. \_\_\_\_\_ ( ) p.m. \_\_\_\_\_ Date of Onset \_\_\_\_\_ Initials of Person Collecting Specimen \_\_\_\_\_ Initials of Person Completing Form \_\_\_\_\_

TEST	SOURCE/ SPECIMEN TYPE (one source type per form)		REASON	
<input type="checkbox"/> Arbovirus Panel <input type="checkbox"/> B. Strep (Gp A) <input type="checkbox"/> B. Strep (Gp B) <input type="checkbox"/> Bacillus anthracis <input type="checkbox"/> Brucella <input type="checkbox"/> Burkholderia <input type="checkbox"/> COVID-19 <input type="checkbox"/> Cyclospora <input type="checkbox"/> Cryptosporidium <input type="checkbox"/> Francisella <input type="checkbox"/> Gonorrhea Culture <input type="checkbox"/> Giardia <input type="checkbox"/> Legionella <input type="checkbox"/> Malaria <input type="checkbox"/> Measles PCR <input type="checkbox"/> Mumps PCR <input type="checkbox"/> MTBC Smear, Cult, ID & Sens	<input type="checkbox"/> MTBC – PCR (Resp. spec. only) <input type="checkbox"/> MTB Genotyping only <input type="checkbox"/> Norovirus <input type="checkbox"/> Orthopox virus <input type="checkbox"/> Pertussis PCR <input type="checkbox"/> Respiratory Panel <input type="checkbox"/> Salmonella <input type="checkbox"/> Shiga-toxin producing E. coli or E. coli O157 <input type="checkbox"/> Shigella <input type="checkbox"/> Staphylococcus aureus <input type="checkbox"/> Varicella-zoster <input type="checkbox"/> Yersinia <input type="checkbox"/> Yersinia pestis <input type="checkbox"/> Vibrio <input type="checkbox"/> Other (Specify Below*)	<input type="checkbox"/> Blood - Film <input type="checkbox"/> Blood - Serum <input type="checkbox"/> Blood - Whole <input type="checkbox"/> Body Fluid (Specify Below**) <input type="checkbox"/> Bronchial Alveolar Lavage "BAL" <input type="checkbox"/> Bronchial Washing <input type="checkbox"/> Fecal Swab <input type="checkbox"/> Genital Swab <input type="checkbox"/> Nasal Aspirate <input type="checkbox"/> Nasopharyngeal Swab <input type="checkbox"/> O&P Kit <input type="checkbox"/> Oropharyngeal Swab <input type="checkbox"/> Pharyngeal Swab <input type="checkbox"/> Rectal Swab <input type="checkbox"/> Referred/Isolated Culture	<input type="checkbox"/> Serum – Acute <input type="checkbox"/> Serum - Convalescent <input type="checkbox"/> Skin <input type="checkbox"/> Smear <input type="checkbox"/> Spinal Fluid <input type="checkbox"/> Stool/Feces <input type="checkbox"/> Sputum <input type="checkbox"/> Tissue Culture Fluid <input type="checkbox"/> Tissue (Specify Below**) <input type="checkbox"/> Throat Swab <input type="checkbox"/> Urine <input type="checkbox"/> Vaginal Swab <input type="checkbox"/> Other (Specify Below**) <input type="checkbox"/> Other Swab (Specify Below**)	<input type="checkbox"/> Carrier <input type="checkbox"/> Confirmation <input type="checkbox"/> Contact <input type="checkbox"/> Diagnosis <input type="checkbox"/> Foodborne Illness <input type="checkbox"/> Immunity <input type="checkbox"/> Outbreak <input type="checkbox"/> Post Vaccination <input type="checkbox"/> Release Specimen <input type="checkbox"/> Routine Screening <input type="checkbox"/> Rule Out Threat Agent <input type="checkbox"/> Symptomatic <input type="checkbox"/> Treatment <input type="checkbox"/> Typing <input type="checkbox"/> Other (Specify Below**)

\*OTHER TEST

\*\*SOURCE

\*\*\*REASON(S)

**OVER- For Referred Cultures and Instructions**



**REFERRED CULTURE INFORMATION**

Agent Suspected \_\_\_\_\_

Morphology \_\_\_\_\_

Carbohydrate Reactions \_\_\_\_\_

Other Biochemical Reaction \_\_\_\_\_

Commercial Kit Used \_\_\_\_\_

Tentative Identification \_\_\_\_\_

Other Pertinent Information

**INSTRUCTIONS**

The Illinois Department of Public Health laboratory requisition form titled, "Communicable Diseases Laboratory Test Requisition," is designed to accompany the specimens submitted to the Department's laboratories by approved submitters for communicable diseases testing, including parasitology, bacteriology, enterics and virus.

**DEFINITION** - Submitter - Entity that sends specimens to be tested.

**SUBMITTER INFORMATION** - Enter the name of the organization/hospital OR submitter code (if you have one) requesting the test, the ordering contact person/clinician's last name (important so that test results may be routed correctly), the address of the organization/hospital requesting the test, and the complete submitter's phone number and FAX, including area code.

**PATIENT INFORMATION** - Print the patient's full name. The patient's ID# is an optional field for a locally assigned patient number completed at the discretion of the submitter. If applicable, enter the patient's Medicaid identification number. Enter the patient's date of birth, if known. If the date of birth is entered, the age may be left blank. Enter sex, race, ethnicity as indicated by the patient. Enter the patient's complete address including apartment or suite number, city/town, state and five digit ZIP code.

**TEST REQUEST INFORMATION** - Enter the date the specimen was collected. This is a REQUIRED field. If applicable, enter the date of patient's illness onset. Please print the initials of person completing the requisition form and the initials of person collecting the specimen. Enter specimen collection time.

To request a test, fill in appropriate box. Fill in box for source and reason. If not listed, use "other" and write appropriate test, source or reason.

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