



COVID-19/INFLUENZA Laboratory Test Requisition

REQUISITION MUST BE FILLED OUT COMPLETELY

Laboratory Specimen Number
(FOR PUBLIC HEALTH USE ONLY)

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

Outbreak #:

SUBMITTING INSTITUTION: _____
Submitting Institution Name

Submitter Address (Street Number, Name of Street) City State ZIP Code

Ordering Provider Name and NPI (If applicable) Telephone Number FAX Number (For results)

PATIENT INFORMATION:

Patient's Last Name First Name Middle Name

Street Address Apartment/Suite Number

City State ZIP Code

Telephone Number Birthday (mm/dd/yyyy) Age

- | | | | |
|---------------------------------|--|---|---------------------------------------|
| Sex | Race | | Ethnicity |
| <input type="checkbox"/> Male | <input type="checkbox"/> White | <input type="checkbox"/> Native American | <input type="checkbox"/> Hispanic |
| <input type="checkbox"/> Female | <input type="checkbox"/> African American/ Black | <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Non-Hispanic |
| | | <input type="checkbox"/> Other/Unknown | |

Patient ID # (optional) _____

INSURANCE INFO

Recipient ID # _____ Insurance Company _____

Group/Policy # _____ Social Security Number _____

Policy Holder Last Name _____ Policy Holder First Name _____

Eligibility Begin Date _____ Eligibility End Date _____

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.

_____ : _____ () a.m.
_____ : _____ () p.m.

Date Collected (mm/dd/yyyy) Time Collected Date of Onset COVID-19 Ag Result

- TEST (Must check one)**
- COVID-19 PCR
 - COVID-19 IgG Antibody
 - INFLUENZA A & B PCR
 - FLU/COVID Multi-plex PCR
 - COVID-19 Ag

- SOURCE/SPECIMEN TYPE (one source type per form)**
- | | |
|--|---|
| <input type="checkbox"/> Anterior Nares Swab | <input type="checkbox"/> Oropharyngeal Swab |
| <input type="checkbox"/> Blood – Serum | <input type="checkbox"/> Plasma |
| <input type="checkbox"/> Bronchial Alveolar Lavage “BAL” | <input type="checkbox"/> Serum – Acute |
| <input type="checkbox"/> Mid-turbinate Nasal Swab | <input type="checkbox"/> Serum – Convalescent |
| <input type="checkbox"/> Nasal Aspirate | <input type="checkbox"/> Sputum |
| <input type="checkbox"/> Nasal Washing | |
| <input type="checkbox"/> Nasopharyngeal Swab | |



INSTRUCTIONS

The Illinois Department of Public Health laboratory requisition form titled, "COVID-19/Influenza Laboratory Test Requisition," is designed to accompany the specimens submitted to the Department's laboratories by approved submitters for COVID-19 testing.

DEFINITION – Submitting Institution - Entity that sends specimens to be tested.

SUBMITTING INSTITUTION - Enter the name of the organization/hospital OR submitter code (if you have one) requesting the test, the ordering provider name and NPI (if applicable), 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 identification number, insurance company name, group/policy number, policy holder first and last name, eligibility begin and end date, and last 4 of SSN. 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. If applicable, enter the date of patient's illness onset. Enter specimen collection time.

Fill in box for source. If not listed, use "other" and write source.

**** Per the Department of Health and Human Services (HHS) guidance, all field must be completed.**

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