ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Request For Respiratory / Influenza Testing

Print using upper case letters.
Do not fax this form to the lab.

SUBMITTER INFORMATION

AUTHORIZATION CODE

SUBMITTER PHONE NUMBER - -

SUBMITTER FAX NUMBER* (see instructions) - -

SUBMITTER'S NAME

STREET ADDRESS (Include apartment/suite number)

CITY

STATE

ZIP CODE

CONTACT PERSON

PHYSICIAN INFORMATION

PHYSICIAN NAME

STREET ADDRESS (Include apartment/suite number)

CITY

STATE

ZIP CODE

PHYSICIAN PHONE NUMBER - -

PHYSICIAN FAX NUMBER * (see instructions) - -

FAX REQUESTED
- Yes
- No

PATIENT INFORMATION

PATIENT'S FIRST NAME

BIRTHDATE / /

AGE

PATIENT'S LAST NAME

MEDICAID IDENTIFICATION NUMBER

PREGNANT
- Yes
- No
- UNK

PATIENT'S IDENTIFICATION NUMBER

RACE
- White
- AfricanAmerican/Black
- NativeAmerican
- Asian/PacificIslander
- Other
- Unknown

ETHNICITY
- Hispanic
- Non-Hispanic

SEX
- Male
- Female

STREET ADDRESS (Include apartment/suite number)

CITY

STATE

ZIP CODE

TEST INFORMATION

DATE COLLECTED / /

INITIALS OF COMPLETIN

ONSET DATE / /

ONLY ONE (1) SAMPLE PER FORM **APPROVED TESTING CRITERIA**

SPECIMEN SOURCE TYPE:

- nasalswab
- nasopharyngealswab
- dualnasopharyngeal/throatswab
- nasalwash
- trachealaspirates
- broncheoalveolarlavage
- throatswab
- bronchialwash
- nasalaspirate
- viralculture
- sputum
- lung tissue

PATIENT IS:

- hospitalized
- congregatefacilityresident
- deceased
- healthcareworker
- in ICU
- associatedwithoutbreak

LAB USE ONLY

Specimen Number Area Below

17760