State of Illinois
Illinois Department of Public Health

Communicable Diseases Laboratory Test Requisition

Authorization Code:_____
(If applicable)

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 #:

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 | Birthday (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.

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

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

*OTHER TEST

**SOURCE

***REASON(S)

OVER- For Referred Cultures and Instructions

State of Illinois
Illinois Department of Public Health

Communicable Diseases Laboratory Test Requisition

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 IDPH laboratories by approved submitters for communicable diseases testing, including parasitology, bacteriology, enteric, 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. Print the initials of the 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.

Illinois Department of Public Health
Division of Laboratories
2121 W. Taylor St.
Chicago, IL 60612
312-793-4760

Illinois Department of Public Health
Division of Laboratories
825 N. Rutledge St.
Springfield, IL 62702
217-782-6562

Illinois Department of Public Health
Division of Laboratories
1155 S. Oakland Ave.
Carbondale, IL 62901
618-457-5131