ILLINOIS DEPARTMENT OF PUBLIC HEALTH
IDPH
PROTECTING HEALTH, IMPROVING LIVES

Print Form

Test Request For Human Arbovirus Panel

Submitter Information

Authorization Number: **Submitter Phone Number:** **Submitter Fax Number:**

Submitting Hospital/Clinic/Laboratory Name:

Submitter Mailing Address: (Please include apartment / suite number)

City **State** **Zip Code**

Physician Name:

Patient Information

Patient Name: (First, Middle, Last) **Date of Birth:**

Patient Address: (Please include apartment / suite number)

City **State** **Zip Code** **Medicaid Recipient ID:**

Sex: ◯ Male ◯ Female **Pregnant?:** ◯ Yes ◯ No **Ethnicity:** ◯ Hispanic ◯ Non-Hispanic

Race: ◯ White ◯ African American/Black ◯ Native American ◯ Asian/Pacific Islander ◯ Other/Unknown

Test Request Information

Specimen Collection Date: **Symptom Onset Date:**

Specimen Source: ◯ **Serum** ◯ **Spinal Fluid** ◯ **Urine** ◯ **Amniotic Fluid** ◯ **Tissue** ◯ **Other** **(Specify)**

Test Requested: ◯ **Zika** ◯ **Chikungunya** ◯ **Dengue** ◯ **West Nile Virus** ◯ **St. Louis Encephalitis** ◯ **California Encephalitis**
◯ **Other** **(Specify)**

Disease Stage: ◯ Acute ◯ Convalescent **Hospitalized:** ◯ Yes ◯ No

Clinical Symptoms: (mark all that apply):
◯ **Fever** ◯ **Headache** ◯ **Stiff Neck** ◯ **Change in Consciousness** ◯ **Lethargy** ◯ **Coma** ◯ **Rash** ◯ **Joint Pain**
◯ **Conjunctivitis** ◯ **Other** **(Specify)**

Patient Travel and Epi Information

City/Country of Exposure: **Travel Dates:** to

City/Country of Exposure: **Travel Dates:** to

Epi Comments:

Lab Use Only

	Bar Code Area Below	

Please provide all requested information. Failure to complete this form entirely may result in testing delays.

Print Form