# ILLINOIS DEPARTMENT OF PUBLIC HEALTH

## Test Request For Human Arbovirus Panel

**Please print using upper case letters.**

## SUBMITTER INFORMATION

SUBMITTER CODE

SUBMITTER PHONE NUMBER – –

SUBMITTER'S NAME

STREET ADDRESS (Please include apartment/suite number.)

CITY | STATE | ZIP CODE

CONTACT PERSON

## PHYSICIAN INFORMATION

PHYSICIAN NAME

STREET ADDRESS (Please include apartment/suite number.)

CITY | STATE | ZIP CODE

PHYSICIAN PHONE NUMBER – –

## PATIENT INFORMATION

PATIENT'S FIRST NAME | BIRTHDATE / / | AGE | Clear

PATIENT'S LAST NAME | MEDICAID RECIPIENT ID # | SEX ○ M ○ F | PREGNANT? ○ Y ○ N

PATIENT'S ID # | RACE ○ White ○ African American/Black ○ Native American ○ Asian/Pacific Islander ○ Other/Unknown | ETHNICITY ○ Hispanic ○ Non-Hispanic

STREET ADDRESS (Please include apartment/suite number.)

CITY | STATE | ZIP CODE

## TEST REQUESTED INFORMATION

DATE COLLECTED / / | ONSET DATE / /

**ONLY ONE (1) SAMPLE PER FORM**

| *SOURCE* | *DISEASE STAGE* | *HOSPITALIZED* | *CLINICAL SYMPTOMS* |
|---|---|---|---|
| ○ Serum | ○ Acute Clear | ○ Yes Clear | ○ Fever ○ Change In Consciousness |
| ○ Spinal Fluid | ○ Convalescent | ○ No | ○ Headache ○ Lethargy |
| | | | ○ Stiff Neck ○ Coma |

## LAB USE ONLY

Bar Code Area Below

20375

IL 482-1059 | Print | d by aut | Reset | Illinois P.O. # 553087 2M 4/03