State of Illinois
Illinois Department of Public Health

Communicable Diseases Laboratory Test Requisition

Laboratory Specimen Number (FOR PUBLIC HEALTH USE ONLY)

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

Outbreak #:

SUBMITTER INFORMATION:

Submitter Code _____ Submitter Name _____

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.

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

TEST		SOURCE/ SPECIMEN TYPE		REASON
❑ Arbovirus Panel	❑ MTBC – PCR (Resp. spec. only)	❑ Blood - Film	❑ Skin	❑ Carrier
❑ B. Strep (Gp A)	❑ MTB Genotyping only	❑ Blood - Serum	❑ Smear	❑ Confirmation
❑ B. Strep (Gp B)	❑ Norovirus	❑ Blood - Whole	❑ Spinal Fluid	❑ Contact
❑ Bacillus anthracis	❑ Orthopox virus	❑ Body Fluid (Specify Below**)	❑ Stool/Feces	❑ Diagnosis
❑ Brucella	❑ Pertussis PCR	❑ Bronchial Washing	❑ Sputum	❑ Foodborne Illness
❑ Burkholderia	❑ Respiratory Panel	❑ Fecal Swab	❑ Tissue Culture Fluid	❑ Immunity
❑ Cyclospora	❑ Salmonella	❑ Genital Swab	❑ Tissue (Specify Below**)	❑ Outbreak
❑ Cryptosporidium	❑ Shigella	❑ Nasal Aspirate	❑ Throat Swab	❑ Post Vaccination
❑ E. coli	❑ Staphylococcus aureus	❑ Nasopharyngeal Swab	❑ Urine	❑ Routine Screening
❑ Francisella	❑ Varicella-zoster	❑ O&P Kit	❑ Vaginal Swab	❑ Rule Out Threat Agent
❑ Gonorrhea Culture	❑ Yersinia	❑ Pharyngeal Swab	❑ Other (Specify Below**)	❑ Symptomatic
❑ Giardia	❑ Yersinia pestis	❑ Rectal Swab	❑ Other Swab (Specify Below**)	❑ Treatment
❑ Malaria	❑ Vibrio	❑ Referred/Isolated Culture		❑ Typing
❑ Measles PCR	❑ Other (Specify Below*)	❑ Serum – Acute		❑ Quarantine Release
❑ Mumps PCR		❑ Serum - Convalescent		❑ Other (Specify Below***)
❑ MTBC Smear, Cult, ID & Sens		Date Collected _____		
		Initials of Collector _____		

*OTHER TEST _____

**SOURCE _____

***REASON(S) _____

OVER- For Referred Cultures and Instructions

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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 the Department's laboratories by approved submitters for communicable diseases testing, including parasitology, bacteriology, enterics 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. Please print the initials of 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.

Chicago Laboratory
2121 W. Taylor St.
Chicago, IL 60612
312-793-4760

Springfield Laboratory
825 N. Rutledge St., P.O. Box 19435
Springfield, IL 62794
217-782-6562

Carbondale Laboratory
1155 S. Oakland Ave., P.O. Box 2797
Carbondale, IL 62901
618-457-5131

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