

**Illinois Department of Public Health
Division of Laboratories
Communicable Diseases Laboratory Test Requisition**

Laboratory Specimen Number
(FOR PUBLIC HEALTH USE ONLY)

Please 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 _____

 Telephone Number _____ Birthday (M/D/Y) _____ Age _____

Sex **Race** **Ethnicity**

Male White Native American Other/Unknown Hispanic

Female African American/ Black Asian/Pacific Islander 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.

_____/_____/_____ : ____ ()AM ____/____/_____ Initials of Person _____ Initials of Person _____
 Date Collected (M/D/Y) Time collected ()PM Date of Onset Collecting Specimen Completing Form

TEST	SOURCE/ SPECIMEN TYPE		REASON	
<input type="radio"/> Arbovirus Panel <input type="radio"/> B. Strep (Gp A) <input type="radio"/> B. Strep (Gp B) <input type="radio"/> Bacillus anthracis <input type="radio"/> Bacillus sp. <input type="radio"/> Blood Parasites <input type="radio"/> Campylobacter <input type="radio"/> C. perfringens Toxin <input type="radio"/> Cyclospora <input type="radio"/> Cryptosporidium <input type="radio"/> E. coli <input type="radio"/> Fecal Parasites <input type="radio"/> Fungus ID <input type="radio"/> GC Culture <input type="radio"/> Giardia <input type="radio"/> Herpes <input type="radio"/> Influenza <input type="radio"/> Leptospirosis <input type="radio"/> Measles IgG	<input type="radio"/> Measles IgM <input type="radio"/> Mumps <input type="radio"/> MTB Smear, Cult, ID &Sens <input type="radio"/> MTB ID Only <input type="radio"/> MTB Sensitivity Only <input type="radio"/> MTD (Direct Test for MTB) <input type="radio"/> Pertussis <input type="radio"/> PSA <input type="radio"/> Respiratory Virus <input type="radio"/> Rubella IgG <input type="radio"/> Salmonella <input type="radio"/> Shigella <input type="radio"/> Staphylococcus aureus <input type="radio"/> Viral Isolation <input type="radio"/> Varicella-zoster <input type="radio"/> Yeast ID <input type="radio"/> Yersenia <input type="radio"/> Yersinia pestis <input type="radio"/> Vibrio <input type="radio"/> Other (Specify Below*)	<input type="radio"/> Blood - Film <input type="radio"/> Blood - Serum <input type="radio"/> Blood - Whole <input type="radio"/> Body Fluid (Specify Below**) <input type="radio"/> Bronchial Washing <input type="radio"/> Fecal Swab <input type="radio"/> Genital Swab <input type="radio"/> Nasopharyngeal Swab <input type="radio"/> O&P Kit <input type="radio"/> Pharyngeal Swab <input type="radio"/> Rectal Swab <input type="radio"/> Referred/Isolated Culture <input type="radio"/> Serum - Acute <input type="radio"/> Serum - Convalescent Date Collected ____/____/_____ Initials of Collector _____	<input type="radio"/> Skin <input type="radio"/> Smear <input type="radio"/> Spinal Fluid <input type="radio"/> Stool/Feces <input type="radio"/> Sputum <input type="radio"/> Tissue Culture Fluid <input type="radio"/> Tissue (Specify Below**) <input type="radio"/> Throat Swab <input type="radio"/> Urine <input type="radio"/> Vaginal Swab <input type="radio"/> Other (Specify Below**) <input type="radio"/> Other Swab (Specify Below**)	<input type="radio"/> Carrier <input type="radio"/> Confirmation <input type="radio"/> Contact <input type="radio"/> Diagnosis <input type="radio"/> Foodborne Illness <input type="radio"/> Grouping <input type="radio"/> Immunity <input type="radio"/> Outbreak <input type="radio"/> Post Vaccination <input type="radio"/> Routine Screening <input type="radio"/> Rule Out Threat Agent <input type="radio"/> Symptomatic <input type="radio"/> Treatment <input type="radio"/> Typing <input type="radio"/> Quarantine Release <input type="radio"/> Other (Specify Below***)

*OTHER TEST

**SOURCE

***REASON(S)

OVER- For Referred Cultures and Instructions

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 (IDPH) laboratory requisition form titled, "Communicable Diseases Laboratory Test Requisition" is designed to accompany the specimens submitted to the IDPH laboratories by approved submitters for communicable diseases testing including parasitology, mycology, 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 circle. Fill in circle for source and reason. If not listed, use "other" and write appropriate test, source or reason.

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

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

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

IDPH Web site: www.idph.state.il.us

Printed by the Authority of the State of Illinois
P.O.#553073 1M 8/02

IL# 482-1039