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