IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

CLINICAL TEST REQUEST FORM

GENERAL INFORMATION:

Patient Name/#: _____ Date of Birth: _____/_____/_____ Gender: ◯ M ◯ F

Patient City and County of Residence: _____ Medicaid #: _____

Onset Date: _____/_____/_____ Collection Date: _____/_____/_____ Part of Outbreak? ◯ No ◯ Yes (Outbreak #: _____)

Specimen Type: ☐ Isolate ☐ Blood ☐ Urine ☐ Stool ☐ Serum ☐ NP aspirate ☐ Swab (◯ Buccal ◯ Nasal ◯ NP ◯ Throat) ☐ Other: _____

SEROLOGY:

HIV
- ☐ HIV Antibody Screen
- ☐ Confirmation of HIV Rapid Test
  Rapid Test Result: _____

Syphilis
- ☐ *Routine* ☐ *Symptomatic*
- ☐ VDRL (◯ serum or ◯ CSF)
- ☐ TPPA

Hepatitis B
- ☐ Surface Antibody (titer)
- ☐ Core Antibody
- ☐ Surface Antigen

Hantavirus ☐ IgG/IgM

Rubella ☐ IgG

Rubeola (Measles) ☐ IgG ☐ IgM

Mumps ☐ IgG ☐ IgM

Varicella ☐ IgG ☐ IgM

West Nile Virus *(onset date required)*
- ☐ IgG/IgM by EIA (serum)
- ☐ IgM by MIA (CSF)

Other ☐ _____
(prior notification required)

IDENTIFICATION/CONFIRMATION:

☐ **Test Requested:** _____

BIOLOGICAL THREAT (LRN-B):

☐ **Rule-out for** _____

VIROLOGY CULTURE:

☐ **Upper Respiratory Virus Panel**
Influenza A & B; Parainfluenza 1,2,3; Adenovirus; Respiratory Syncytial Virus

☐ **Enterovirus Culture**
Coxsackie, Enterovirus, Polio, Echovirus

☐ **Other Virus Culture:** _____
(prior notification required)

MOLECULAR TESTING:

☐ **Mumps RT-PCR**

☐ **Measles RT-PCR**

☐ **Norovirus RT-PCR**

☐ **Pertussis RT-PCR**
Is patient currently on antibiotics? ◯ No ◯ Yes

☐ **Other RT-PCR:** _____
(prior notification required)

SURVEILLANCE/SEROTYPING/TEST OF CURE:

☐ **Salmonella**

☐ **Shiga toxin-producing E. coli**

☐ **Shigella**

☐ **Listeria**

☐ **Cryptosporidium/Giardia**

☐ **Other Surveillance:** _____

COMMENTS:

_____

_____

REPORTING:

Send report to:
Facility: _____
Attention: _____
Address: _____
City/State/Zip: _____
Phone: _____

Send copy to:
Facility: _____
Attention: _____
Address: _____
City/State/Zip: _____
Phone: _____

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