



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 IgG/IgM by EIA (serum)
 (onset date required) IgM by MIA (CSF)

Other _____
 (prior notification required)

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: _____

IDENTIFICATION/CONFIRMATION:

Test Requested: _____

BIOLOGICAL THREAT (LRN-B):

Rule-out for _____

COMMENTS:

REPORTING:

| | |
|---|---|
| <p>Send report to: Facility: _____ Attention: _____ Address: _____ City/State/Zip: _____ Phone: _____</p> | <p>Send copy to: Facility: _____ Attention: _____ Address: _____ City/State/Zip: _____ Phone: _____</p> |
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