Arbovirus Test Requisition

Must complete submitter information and include the name of the authorized person requesting the test.

Patient's first and last names must be on the specimen container and match exactly to the lab slip.

Indicate patient's race, ethnicity and sex.

Fill in the date specimen was collected.

Onset date field **must** be completed. Onset date of patient's symptoms is required for Arbovirus results interpretation.

Indicate CSF or serum to order Arbovirus IgM Panel testing..Complete patient's travel history, symptoms, and vaccination history.

Use only these codes to provide the source of the specimen.

Go to the DHMH Laboratory website for further information: www.dhmh.maryland.gov/laboratories

Laboratories Administration MD DHMH
201 W. Preston St. • Baltimore, MD 21201
P.O. Box 2355 • Baltimore, MD 21203-2355
410-767-6100 http://dhmh.maryland.gov/laboratories/
Robert A. Myers, Ph.D., Director

SEROLOGICAL TESTING

STATE LAB Use Only

TYPE OR PRINT REQUIRED INFORMATION OR PLACE LABELS ON ALL FOUR CORNERS

☐EH ☐FP ☐MTY/PN ☐NOD ☐STD ☐TB ☐CD ☐COR
Health Care Provider
Address
City County
State Zip Code
Contact Name
Phone # Fax #
Test Request Authorized by:

Patient SS# (last 4 digits):
Last Name ☐SR ☐JR ☐Other
First Name M.I. Maiden:
Date of Birth (mm/dd/yyyy) / /
Address
City County
State Zip Code
Sex: ☐Male ☐Female ☐Transgender M to F ☐Transgender F to M
Ethnicity: Hispanic or Latino Origin? ☐yes ☐no
Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/other Pacific Islander ☐White
Case # DOC# Outbreak # Submitter Lab #
Collect Date: Collect Time: ☐am ☐pm *Vaccination History:
Previous Test Done? ☐no ☐yes Name of Test Date ☐1st ☐2nd ☐3rd State Lab Number:
Name of Test Date ☐1st ☐2nd ☐3rd State Lab Number:
Onset Date: Exposure Date: ☐ Clinical Illness/Symptoms

SPECIMEN CODE

Arbovirus / West Nile Virus Panel (Serum or CSF)
Provide dates of onset & collection (see above)
Required information, check all that apply:
DIAGNOSIS: ☐aseptic meningitis ☐encephalitis
☐other
SYMPTOMS: ☐headache ☐fever ☐stiff neck
☐altered mental status ☐muscle weakness
☐rash ☐other
ILLNESS FATAL? ☐yes ☐no
TRAVEL HISTORY (dates and places)
IMMUNIZATIONS: Yellow fever? ☐yes ☐no
Flavivirus? ☐yes ☐no
IMMUNOCOMPROMISED? ☐yes ☐no

Aspergillus
Brucella
Chlamydia (group antigen IgG)
Cryptococcal antigen)
Cytomegalovirus (CMV)
Ehrlichia
Epstein-Barr Virus (EBV)
*Hepatitis A Screen (IgM Ab only, acute infection)
Call lab (410-767-6169) prior to submitting
Hepatitis B Screen (HBsAg only)
Prenatal patient? ☐yes ☐no
*Hepatitis B Panel: (HBsAg, HBsAb)
*Hepatitis B post vaccine (HBsAb)
Hepatitis C screen (HCV Ab only)

SPECIMEN CODE

Herpes Simplex Virus (HSV) Types 1&2
Legionella
Leptospira
Lyme Disease
*MMRV Immunity Screen: [Measles (Rubeola), Mumps, Rubella, Varicella (Chickenpox) IgG Ab only]
Mononucleosis - Infectious
*Mumps Immunity Screen
Mycoplasma
Rocky Mountain Spotted Fever (RMSF)
*Rabies (RFFIT) (*List vaccination dates above)
*Rubella Immunity Screen
*Rubeola (Measles) Immunity Screen
Syphilis - Previously treated? ☐yes ☐no
Toxoplasma
Tularemia
Varicella Immunity Screen
VDRL (CSF only)
CDC/Other Test(s)
Add'l Specimen Codes
Prior arrangements have been made with the following DHMH Labs Administration employee:
Please Note Vaccination History Above*

SPECIMEN CODE
LAVENDER TOP TUBE REQUIRED
Hemoglobin Disorders
Blood transfusion? (last 4 months) ☐yes ☐no
Prenatal screen? ☐yes ☐no
Father of baby screen? ☐yes ☐no
Guardian's name if patient is a minor:
Name of mother of "at risk" baby:

SPECIMEN CODE:
PLACE CODE IN BOX NEXT TO TEST
B Blood (5 ml)
CSF Cerebrospinal Fluid
L Lavender Top Tube
P Plasma
S Serum (1 ml per test)
UR Urine

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