NJDOH ARBOVIRAL TESTING REQUEST

Medical Record# ________________ CDRSS #: _____________

LABORATORY TESTS REQUESTED:____

PATIENT/FACILITY INFORMATION

Last Name	First Name	Middle Initial	DOB: ____ / ____ / ______	Sex ☐ Male ☐ Female
Street Address	**City/State**	**Zipcode**	**County**	**Municipality**

Telephone (   ) _____ - _______

Race ☐White ☐Black ☐Asian ☐Other ☐Unknown ☐Native Hawaiian/Pacific Islander ☐American Indian/Alaskan

Ethnicity ☐ Hispanic ☐ Non-Hispanic

Occupation (job title)

Industry (work setting)

Hospitalized ☐ Yes ☐ No

Admission date: ____/____/_____

Hospital Name

Hospital Address

Discharge date: _____/____/_____

Ordering Physician Name/Address:

Name: ____

Address: ____

Phone: (   ) _____ - _______ Fax: (   ) _____ - _______

E-mail:

Submitting Facility/Laboratory:

Contact Name: _______________________________________

Facility: ____

Phone: (   ) _____ - _______ Fax: (   ) _____ - _______

E-mail:

CLINICAL INFORMATION

Pregnant ☐ Yes ☐ No

Date of illness onset: ____/____/_______

If patient died, date of death: ____/____/_______

Current Diagnosis: ☐ Encephalitis ☐ Meningitis ☐ Other, specify:_________________________________

Signs/Symptoms (check):

Symptom	Yes	No	Symptom	Yes	No
Fever _______°F	☐ Yes	☐ No	Altered mental status	☐ Yes	☐ No
Headache	☐ Yes	☐ No	Stiff neck/meningeal signs	☐ Yes	☐ No
Myalgia	☐ Yes	☐ No	Muscle weakness/paralysis	☐ Yes	☐ No
Rash	☐ Yes	☐ No	Seizures	☐ Yes	☐ No

Other symptoms, specify:

LABORATORY INFORMATION/TEST RESULTS

CSF Test Date___/___/_____ Glucose _________ Protein _________ WBC________ Diff: Segs%________ Lymphs%________

CBC Date: ___/___/_____ Abnormal? ☐ Yes ☐ No WBC _______ Platelets_______ Diff: Segs%______ Lymphs%_______

Check if tests were ordered and specify result:

Test	Pos	Neg	Pending	Test	Pos	Neg	Pending
☐ Cytomegalovirus	☐ Pos	☐ Neg	☐ Pending	☐ La Crosse virus	☐ Pos	☐ Neg	☐ Pending
☐ Enteroviruses	☐ Pos	☐ Neg	☐ Pending	☐ St. Louis Encephalitis	☐ Pos	☐ Neg	☐ Pending
☐ Epstein Barr Virus	☐ Pos	☐ Neg	☐ Pending	☐ Varicella Zoster	☐ Pos	☐ Neg	☐ Pending
☐ Herpes Simplex virus	☐ Pos	☐ Neg	☐ Pending	☐ West Nile Virus	☐ Pos	☐ Neg	☐ Pending

Other relevant tests performed, specify:

Brain imaging scan performed:__________ Date: ___/___/_____ Abnormal? ☐ Yes ☐ No Result:__________________

EXPOSURE / PRIOR HISTORY / VACCINATION INFORMATION

In the 30 days before illness onset or diagnosis, did patient -

Spend time outdoors in grassy or wooded areas? ☐ Yes ☐ No Location/dates: ________________________________

Notice a tick bite? ☐ Yes ☐ No Date: _____/_____/________

Travel outside of NJ (within the US)? ☐ Yes ☐ No Location/dates:____

Travel outside of the US? ☐ Yes ☐ No Location/dates:____

Receive ☐ Blood transfusion ☐ Organ transplant

Did the patient have a prior flavivirus infection (e.g., WNV, Zika, Dengue, Yellow Fever)? ☐ Yes ☐ No

Is the patient vaccinated against a flavivirus (e.g., Japanese Encephalitis, Yellow Fever, Dengue)? ☐ Yes ☐ No

Submit via encrypted email to CDSVectorTeam@doh.nj.gov or fax to 609-826-4874. Questions? Call 609-826-5964