

# NJDOH ARBOVIRAL TESTING REQUEST

Medical Record# \_\_\_\_\_ CDRSS #: \_\_\_\_\_

LABORATORY TESTS REQUESTED: \_\_\_\_\_

PATIENT/FACILITY INFORMATION				
Last Name	First Name	Middle Initial	DOB: ____ / ____ / ____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address	City/State	Zipcode	County	Municipality
Telephone ( ) ____ - ____	Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> American Indian/Alaskan		Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
Occupation (job title)	Industry (work setting)	Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No		Admission date: ____ / ____ / ____
Hospital Name	Hospital Address			Discharge date: ____ / ____ / ____
Ordering Physician Name/Address: Name: _____ Address: _____ Phone: ( ) ____ - ____ Fax: ( ) ____ - ____ <b>E-mail:</b> _____			Submitting Facility/Laboratory: Contact Name: _____ Facility: _____ Phone: ( ) ____ - ____ Fax: ( ) ____ - ____ <b>E-mail:</b> _____	
CLINICAL INFORMATION				
Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of illness onset: ____ / ____ / ____		If patient died, date of death: ____ / ____ / ____	
Current Diagnosis: <input type="checkbox"/> Encephalitis <input type="checkbox"/> Meningitis <input type="checkbox"/> Other, specify: _____				
Signs/Symptoms (check):				
Fever _____°F	<input type="checkbox"/> Yes <input type="checkbox"/> No	Altered mental status	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stiff neck/meningeal signs	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Myalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle weakness/paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other symptoms, specify: _____				
LABORATORY INFORMATION/TEST RESULTS				
CSF Test Date ____ / ____ / ____ Glucose _____ Protein _____ WBC _____ Diff: Segs% _____ Lymphs% _____				
CBC Date: ____ / ____ / ____ Abnormal? <input type="checkbox"/> Yes <input type="checkbox"/> No WBC _____ Diff: Segs% _____ Lymphs% _____				
Check if tests were ordered and specify result:				
<input type="checkbox"/> Cytomegalovirus	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pending	<input type="checkbox"/> La Crosse virus	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pending	
<input type="checkbox"/> Enteroviruses	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pending	<input type="checkbox"/> St. Louis Encephalitis	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pending	
<input type="checkbox"/> Epstein Barr Virus	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pending	<input type="checkbox"/> Varicella Zoster	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pending	
<input type="checkbox"/> Herpes Simplex virus	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pending	<input type="checkbox"/> West Nile Virus	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pending	
Other relevant tests performed, specify: _____				
Brain imaging scan performed: _____ Date: ____ / ____ / ____ Abnormal? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Location/dates: _____				
Notice a tick bite? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: ____ / ____ / ____				
Travel outside of NJ (within the US)? <input type="checkbox"/> Yes <input type="checkbox"/> No Location/dates: _____				
Travel outside of the US? <input type="checkbox"/> Yes <input type="checkbox"/> No Location/dates: _____				
Receive <input type="checkbox"/> Blood transfusion <input type="checkbox"/> Organ transplant				
Did the patient have a prior flavivirus infection (e.g., WNV, Zika, Dengue, Yellow Fever)? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is the patient vaccinated against a flavivirus (e.g., Japanese Encephalitis, Yellow Fever, Dengue)? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Submit via encrypted email to [CDSVectorTeam@doh.nj.gov](mailto:CDSVectorTeam@doh.nj.gov) or fax to 609-826-4874. Questions? Call 609-826-5964