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: ____/____/_____

Discharge date: _____/____/_____

Hospital Name	**Hospital Address**

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):

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 _____ Diff: Segs%_____ Lymphs%_____

Check if tests were ordered and specify result:

☐ 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

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