



Arboviral Lab Submission Form

Submitter Information

Authorization Number: 17- Submitter Phone Number: Submitter Fax Number:

Submitting Hospital/Clinic/Laboratory Name:

Submitter Mailing Address: (Please include apartment / suite number)

City State Zip Code

Physician Name:

Patient Information

Patient Name: (First, Middle, Last) Date of Birth:

Patient Address: (Please include apartment / suite number) Patient Phone Number:

City State Zip Code Medicaid Recipient ID:

Sex: Male Female Ethnicity: Hispanic Non-Hispanic

Race: White African American/Black Native American Asian/Pacific Islander Other/Unknown

Test Request Information

Specimen Collection Date: Symptom Onset Date:

Specimen Source: Serum Spinal Fluid Urine Amniotic Fluid Tissue Other (Specify)

Test Requested: Zika Chikungunya Dengue West Nile Virus St. Louis Encephalitis California Encephalitis
 Other (Specify)

Disease Stage: Acute Convalescent Hospitalized: Yes No Pregnant: Yes No

Clinical Symptoms: (mark all that apply):
 Fever Headache Stiff Neck Change in Consciousness Lethargy Coma Rash Joint Pain
 Conjunctivitis Other (Specify)

Patient Travel and Epi Information

State/City/Country of Exposure: Travel Dates: _____ to _____

State/City/Country of Exposure: Travel Dates: _____ to _____

Epi Comments:

(If testing for Zika and exposure was sexual add details here)
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* Include partners travel history with departure and return dates, date of unprotected sex and symptom onset date.

Lab Use Only

Bar Code Area Below

Please provide all requested information. Failure to complete this form entirely may result in testing delays.