ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Request For Respiratory / Influenza Testing

Print using upper case letters.
Do not fax this form to the lab.

SUBMITTER INFORMATION

AUTHORIZATION CODE

SUBMITTER PHONE NUMBER - -

SUBMITTER FAX NUMBER* (see instructions) - - -

SUBMITTER'S NAME

STREET ADDRESS (Include apartment/suite number)

CITY

STATE

ZIP CODE

CONTACT PERSON

PHYSICIAN INFORMATION

PHYSICIAN NAME

STREET ADDRESS (Include apartment/suite number)

CITY

STATE

ZIP CODE

PHYSICIAN PHONE NUMBER - -

PHYSICIAN FAX NUMBER * (see instructions) - -

FAX REQUESTED
○ Yes ○ No

PATIENT INFORMATION

PATIENT'S FIRST NAME

BIRTHDATE / /

AGE

PATIENT'S LAST NAME

MEDICAID IDENTIFICATION NUMBER

PREGNANT
○ Yes ○ No ○ UNK

PATIENT'S IDENTIFICATION NUMBER

RACE
○ White
○ AfricanAmerican/Black
○ NativeAmerican
○ Asian/PacificIslander
○ Other
○ Unknown

ETHNICITY
○ Hispanic
○ Non-Hispanic

SEX
○ Male
○ Female

STREET ADDRESS (Include apartment/suite number)

CITY

STATE

ZIP CODE

TEST INFORMATION

DATE COLLECTED / /

INITIALS OF COMPLETIN

ONSET DATE / /

ONLY ONE (1) SAMPLE PER FORM **APPROVED TESTING CRITERIA**

SPECIMEN SOURCE TYPE:

○ nasalswab	○ nasopharyngealswab	○ dualnasopharyngeal/throatswab
○ nasalwash	○ trachealaspirates	○ broncheoalveolarlavage
○ throatswab	○ bronchialwash	○ nasalaspirate
○ viralculture	○ sputum	○ lung tissue

PATIENT IS:

○ hospitalized	○ congregatefacilityresident
○ deceased	○ healthcareworker
○ in ICU	○ associatedwithoutbreak

LAB USE ONLY

Specimen Number Area Below

17760