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):

Fever:____°F	☐ Yes	☐ No	Stiff neck/meningeal signs	☐ Yes	☐ No
Headache	☐ Yes	☐ No	Muscle weakness/paralysis	☐ Yes	☐ No
Myalgia	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Rash	☐ Yes	☐ No	Other symptoms: _____		
Altered mental status	☐ Yes	☐ No			

Treatment (check):

Was patient treated with doxycycline? ☐ Yes ☐ No

Doxycycline dates: _____/____/_____ to _____/____/_____

Did patient's clinical status improve with doxycycline? ☐ Yes ☐ No

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:

☐ 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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