



IDAHO DEPARTMENT OF HEALTH & WELFARE

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CLINICAL TEST REQUEST FORM

GENERAL INFORMATION:

Patient Name/#: _____ Date of Birth: ____/____/____ Gender: M F
Patient City and County of Residence: _____ Medicaid #: _____
Onset Date: ____/____/____ Collection Date: ____/____/____
Specimen Type: Serum NP aspirate Swab (Buccal Nasal NP Throat) Other: _____

SEROLOGY:

HIV HIV Antibody Screen
Confirmation of HIV Rapid Test
Rapid Test Result: _____
Syphilis Routine Symptomatic
VDRL (serum or CSF)
TPPA
Hepatitis B Surface Antibody (titer)
Core Antibody
Surface Antigen
Hantavirus IgG/IgM
Rubella IgG
Rubeola (Measles) IgG IgM
Mumps IgG IgM
Varicella IgG IgM
West Nile Virus IgG/IgM by EIA (serum)
IgM by MIA (CSF)
Other _____
(prior notification required)

VIROLOGY CULTURE:

Upper Respiratory Virus Panel
Influenza A & B; Parainfluenza 1,2,3; Adenovirus;
Respiratory Syncytial Virus
Enterovirus Culture
Coxsackie, Enterovirus, Polio, Echovirus
Mumps Virus Culture
Herpes Simplex Virus Culture
Other Virus Culture: _____

MOLECULAR TESTING:

Is this part of an outbreak? No Yes (Outbreak #: _____)
Mumps RT-PCR
Measles RT-PCR
Norovirus RT-PCR
Pertussis RT-PCR
Is patient currently on antibiotics? No Yes
Other RT-PCR: _____
(prior notification required)

COMMENTS:

REPORTING:

Send report to: Facility: _____ Attention: _____ Address: _____ City/State/Zip: _____ Phone: _____
Send copy to: Facility: _____ Attention: _____ Address: _____ City/State/Zip: _____ Phone: _____