Arboviral Testing
(Shaded area for laboratory use only)

ALABAMA DEPARTMENT OF PUBLIC HEALTH
BUREAU OF CLINICAL LABORATORIES

8140 AUM Drive, Montgomery, AL 36117-7110, Shipping
P.O. BOX 244018, Montgomery, AL 36124-4018, Mail
Telephone Number: (334) 260-3400

Lab # _____

Name: Last | First | MI

County Health Dept. CHR Number ☐ | **Date Of Birth** MM DD YY

Sex | **Race** | **Date Collected** MM DD YY

Medicaid Number

Social Security Number

Date Received MM DD YY

CPT Code #1	CPT Code #2	CPT Code #3	CPT Code #4

Specimen Submitted: ☐ CSF ☐ Acute Serum ☐ Convalescent Serum ☐ Other _____

Test Requested: ☐ WNV ☐ EEE ☐ SLE ☐ LaCrosse ☐ Other _____

Date of Onset: ____/____/____ **Patient Status:** ☐ Ill ☐ Recovered ☐ Hospitalized ☐ Died

Clinical Diagnosis: _____

Clinical Symptoms: *(Check all that apply)*
☐ Fever (_____°F) ☐ Altered mental state ☐ Seizures
☐ Headache ☐ Stiff neck ☐ Muscle weakness
☐ Other neurologic signs _____ ☐ Other _____

CSF Findings: WBC count _____ Seg(%) _____ Lymphs (%) _____ Glucose _____ Protein _____

Vaccine History:
Has the patient ever had? *(Check all that apply)*
☐ Military service ☐ Yellow fever vaccine ☐ Japanese encephalitis vaccine
☐ Dengue fever ☐ Flavivirus infection ☐ None of the above

Travel History: In the 2 weeks prior to onset, did the patient

	Yes	*No*	*Unknown*	*If yes, where?*	*If yes, dates:*
Travel outside the United States?					
Travel outside Alabama?					

LABORATORY REPORT

(These tests are not FDA approved and are for research purposes only.)

Test(s)	*Virus(es)*	*Results*	*P/N*

(Interpretations of results are on the reverse side.)

☐ Unsatisfactory, _____; Please submit _____.

Mail to: _____

Phone: (_____) _____ - _____

Analyst	Date Reported:	MM	DD	YY

ADPH-F-BCL-140 (8/02)

Provider Number