NEBRASKA PUBLIC HEALTH LABORATORY
UNIVERSITY OF NEBRASKA MEDICAL CENTER
BOX 981180 600 SOUTH 42ND STREET OMAHA NEBRASKA 68198-1180
PHONE: (402) 559-2440 FAX: (402) 559-9497

SPECIAL MICROBIOLOGY REQUISITION

PATIENT LAST NAME **FIRST NAME** **MI**

SUBMITTED BY:
Name : _____
Address: _____
_____
Phone: (____)____-_____
Fax: (____)____-_____
UPIN No.: _____

Test approved by: _____
v. 2016

DATE OF BIRTH / / **AGE** **SEX** M / F
ADDRESS **APT**
CITY **STATE** **ZIP**
COUNTY CODE **STATE CODE** **SURVEILLANCE SITE**
PHYSICIAN'S NAME **PHONE #**
COLLECTION DATE / / **COLLECTION TIME** **AM / PM**
ID / CHART NUMBER (NUMBER WILL APPEAR ON REPORT)

Clinical Diagnosis:_____ **ICD 9 Code:**_____

Race ___White ___Black ___Native American ___Asian/Pacific Islander ___Unknown ___Other_____

Ethnicity ___Hispanic ___Non-Hispanic ____Unknown

Source:_____Bronchial Aspirate _____CSF _____Genital _____Nasopharyngeal _____Sputum _____Stool
_____Throat _____Urine _____Blood ____ Amniotic Fluid _____Other _____

_____West Nile Virus IgM Capture ELISA (CSF)

_____Other Arboviral IgM Capture ELISA (CSF)

_____Other Arboviral PCR (CSF)

***Serum must be accompanied by CSF to be run at public health expense*.**

_____West Nile Virus IgG/IgM Capture ELISA Acute (serum)

CSF Submitted: Yes / No

CSF Previously Submitted: Yes / No

_____West Nile Virus IgG/IgM Capture ELISA Convalescent (serum)

CSF Previously submitted: Yes / No

Acute Serum IgG/IgM Previously Submitted: Yes / No

_____Other Arboviral _____

IgG/IgM Capture ELISA Acute (serum)

CSF Submitted: Yes / No

CSF Previously Submitted: Yes / No