Public Health Ontario | Santé publique Ontario

For laboratory use only
PHO Laboratory No.:

Arbovirus[Ω] (Non-Zika*) Testing Intake Form

Examples of arboviruses which require this form include: West Nile virus (PCR requests only), California serogroup viruses, dengue virus, eastern equine encephalitis virus, Japanese encephalitis virus, Powassan virus, Ross River virus, tick-borne encephalitis virus, Venezuelan equine encephalitis virus, western equine encephalitis virus, and yellow fever virus.

All specimens submitted for testing **MUST BE ACCOMPANIED** by a separate Public Health Ontario Laboratory General Test Requisition for each specimen type collected, e.g. serum, CSF. All fields on each requisition must be completed, including the following **MANDATORY** information:

ALL Sections of this form must be completed.

1 - Requesting Authorized Health Care Provider

Name of responsible healthcare provider / Main responsible physician / Attending physician.

Surname, First Name:

OHIP / CPSO / Prof. License No:

Name of clinic / facility / health unit:

Phone: Fax:

Email:

Alternative contact:

Surname, First name:

OHIP / CPSO / Prof. License No.:

Phone: Fax:

Email:

Form submission date (yyyy/mm/dd):

2 - Arbovirus Test Requested

Arbovirus Test(s) Requested:

☐ If applicable, PHO Laboratory Specimen ID number(s):

3 - Clinical Information

A. Exposures compatible with arbovirus infection

☐ Tick Bite
☐ Mosquito Bite(s)

Other relevant exposures:

Exposure date (yyyy/mm/dd):

B. Relevant clinical information:

☐ Fever ☐ Conjunctivitis ☐ Pregnancy
☐ Rash ☐ Meningitis ☐ Suspected Severe Dengue
☐ Joint Pain ☐ Encephalitis

C. Other relevant clinical details

This information should be provided by the attending healthcare provider / microbiologist involved in the case.

4 - Patient Information

Last Name:

First Name:

Date of Birth (yyyy/mm/dd):

Country(ies), provinces or other locations visited:

Dates of travel (yyyy/mm/dd): Date of arrival to area (yyyy/mm/dd):

Date of departure from area (yyyy/mm/dd):

Comments:

5 - Specimen Characteristics**

☐ Serum ☐ Cerebrospinal Fluid[‡] ☐ Whole Blood
☐ Other If Other, specify:

Specimen 1 collection date (yyyy/mm/dd):

Specimen 2 collection date (yyyy/mm/dd):

☐ Acute ☐ Convalescent

Date of symptom onset (yyyy/mm/dd):

6 - History / date of receiving any arbovirus vaccine or prior arbovirus infection.

Arbovirus Vaccination(s): ☐ Yes ☐ No

Name of vaccine(s):

Date(s) of vaccination(s) (yyyy/mm/dd):

Previous arbovirus infection: ☐ Yes ☐ No

If yes, specify infection:

Date of previous infection (yyyy/mm/dd):

[Ω] If only ordering West Nile virus serology, no arbovirus intake form is required.

* For Zika testing, complete the Zika Mandatory Intake Form, NOT the arbovirus intake form.

**California serology requires paired acute / convalescent sera or paired CSF / sera. See NML California Serogroup Guidelines.

[‡] If CSF is submitted, it must be accompanied by a corresponding serum. For testing guidance on specific arboviruses see Public Health Ontario Test Information Index.

To arrange arbovirus molecular testing (PCR), except Chikungunya / Zika / Dengue PCRs (which do not require approval), contact PHOL Customer Service Centre.

Ontario