TEST REQUEST FORM

DEPARTMENT OF NEUROVIROLOGY
NATIONAL INSTITUTE OF MENTAL HEALTH AND NEUROSCIENCES (NIMHANS)
(Completed form to be sent along with samples)

Name of the Patient	
Age and Sex	
Name of the hospital	
Request sent by	
Samples sent & date of collection	
Mobile number of physician	
Email ID of physician (mandatory)	
Email ID of patient/ attender	
Email ID/IDs to which reports are to be sent (in CAPITALS)**	

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Brief Clinical History	

Diagnostic Test Requested: (Kindly tick appropriately)*

Serology: ELISA	**Molecular: Real time PCR**
□ Measles IgG (CSF) □ Japanese encephalitis IgM (CSF) □ Japanese encephalitis IgM (Serum) □ HSV IgG (CSF)	□ HSV-1 (CSF) □ Enterovirus (CSF) □ JC (CSF) □ Chikungunya(CSF) □ Chikungunya (Serum) □ Streptococcus pneumoniae (CSF) □ Influenza A H1N1 (Throat swab in viral transport medium)

*Please specify the test to be performed. Requests with general terms like 'viral panel' or 'encephalitis panel' etc, will not be accepted.