

Influenza Hospitalized Submission and Test Request Form

* Required Fields

Submitter

*Submitting Facility:
(Results sent here)

*Address: _____

City: _____ State: _____ Zip: _____

Name of Person Filling Out Form: _____

Phone # for questions/alert values: _____

Ordering Provider: _____

Project Number: 1492

Patient

*Last Name: _____

*First Name: _____ MI: _____

Patient Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____

Patient MRN #: _____

*DOB (mm/dd/yyyy): _____

Sex:	Race:
Male	American Indian/Alaska Native
Female	Asian
Other or Unknown	Black
Ethnicity:	Native Hawaiian/Pacific Islander
Hispanic/Latino	White
Non-Hispanic/Latino	Other not listed
Not Provided	Unknown/Not Provided

Specimen

Sample ID: _____

*Date of Collection (mm/dd/yyyy): _____

Time of Collection (##:##): _____ AM PM

*Transport Media: _____ *Storage Condition Prior to Transport: _____

VTM/UTM	Refrigerated
Saline	Frozen

*Source: Nasal Swab
 Nasopharyngeal Swab (NP Swab)
 Oropharyngeal Swab (OP Swab, Throat Swab)
 Other, specify: _____

Collection Facility Information

Collection Facility Name: _____

Collection Facility is the same as Submitting Facility.
 Skip to section - Facility Type

Address: _____

City: _____ State: _____ Zip: _____

Patient Contact/Tracing Information

*Is the patient a resident of a congregate care facility?
 Yes No Unknown

*Is the patient a healthcare worker with direct patient contact?
 Yes No Unknown

*Does patient have symptoms? If yes, check all that apply:

sore throat	shortness of breath
nasal congestion	difficulty breathing
runny nose	chills
cough	fatigue
new loss of taste	muscle or body aches
new loss of smell	nausea
headache	vomiting
fever over 104	diarrhea
feeling feverish	Onset Date: _____

*Hospitalization:
 Patient is Not Hospitalized Patient is Hospitalized Patient is in ICU

Hospital Admission Date if applicable: _____

Employer: _____

Occupation: _____

School (K-12, college /university) or Childcare Attendance: _____

Test Information and Comments

Has patient been vaccinated for influenza? Yes No
 Unknown Vaccination Date: _____

*Previous Influenza result?
 A positive B positive Subtype:
 A negative B negative

*Test type?
 Rapid PCR Culture FA

Test Requested: Influenza and COVID-19 PCR (various assays)

Submitting Laboratory, Specify Any Other Information: _____