NEBRASKA PUBLIC HEALTH LABORATORY
UNIVERSITY OF NEBRASKA MEDICAL CENTER
981180 NEBRASKA MEDICAL CENTER OMAHA, NEBRASKA 68198-1180
TOLL FREE: 866.290.1406 PHONE: (402) 559-2440 FAX: (402) 559-9497
WWW.NPHL.ORG

SPECIAL INFLUENZA MICROBIOLOGY REQUISITION

PATIENT LAST NAME | | | | | | | | | | | | | | | | | | | | | | | FIRST NAME | | | | | | | | | | | | | | | | | | | | | | | | MI

Submitting Laboratory Information

Laboratory Name and Address

____
____
____

Telephone: ____________________________
Fax Number: ___________________________

Contact Name (printed): _________________

Test approved by: Safranek/Williams 2018-2019
Related to Outbreak: ___ YES ___ NO

DATE OF BIRTH ___/___/___ AGE ____ SEX M / F

ADDRESS | | | | | | | | | | | | | | | | | | | | | | | APT

CITY | | | | | | | | | | | | | | | | | | | | | | STATE ZIP

COUNTY CODE | | | STATE CODE | | | SURVEILLANCE ID NUMBER | | | | | | | | | | |

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: ____Nasopharyngeal Swab ____ Nasopharyngeal Washing ___ BAL _____Other: ____________________________________

___ **Influenza Surveillance Testing** - INFLUENZA PCR Panel (CDC)
Submitting Facility: ___ Sentinel Hospital Laboratory ___ Sentinel Provider ___ Other______________________

Onset Date of Symptoms: ____/____/201___ Has this pt received an antiviral? ___ YES ___ NO

Was patient vaccinated for influenza this season (at least 14 days prior to onset of symptoms)? ____YES ____NO
If yes, how many doses: __One __Two If yes, type of vaccine: ___Inactivated Normal Dose (shot)
___ Inactivated High Dose (shot)
___ Quadrivalent ___ Trivalent

Inpatient? ____ Outpatient? _____
Is this patient hospitalized in the ICU? _____YES _____NO
Is this patient pregnant? _____YES _____NO
Is this patient a healthcare worker? _____YES _____NO
Has this patient had contact with swine? _____YES _____NO

Has this patient travelled (at least 14 days prior to onset of symptoms)? _____YES _____NO
If yes, where? _________________________________

Rapid influenza antigen detection test kit performed: _____YES _____NO
Rapid influenza antigen detection test kit name? ______________________________
Influenza A test results: ____Positive ____Negative ___Not Performed
Influenza B test results: ____Positive ____Negative ___Not Performed