**Influenza Surveillance Testing - INFLUENZA PCR Panel (CDC)**

Submiting 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