

**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 2012/2013  
 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:  Hospital  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)  
 FluMist  Intradermal

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  
 Influenza A test results:  Positive  Negative  Not Performed  
 Influenza B test results:  Positive  Negative  Not Performed