

INFLUENZA SURVEILLANCE SUBMISSION FORM 2020–2021

SUBMISSION INSTRUCTIONS

- Fill out the form as completely and legibly as possible. Fields in **bold** and marked with an asterisk (*) are required for testing.
- Record the full patient name, date of birth, and specimen collection date on both this form and the specimen container in case the form and container are separated.
- Specimens should be packaged and shipped on ice packs for overnight delivery as a Category B Dangerous Good (UN3373). If testing is not possible within 72 hours of collection, specimen may be stored frozen and shipped frozen to IBL. Refer to instructions included with prepaid shipper.
- Leaking specimens, calcium alginate, cotton, or wooden shafted swabs will be rejected.

**LAB USE ONLY
DO NOT MARK**

SUBMITTER

Submitting Provider/Facility*

Facility: _____
 Address: _____
 City/State/Zip: _____
 Phone: _____
 Fax: _____

Additional copy to:

Facility: _____
 Address: _____
 City/State/Zip: _____
 Phone: _____
 Fax: _____

SPECIMEN INFORMATION

Collection Date* (mm/dd/yy): _____

Outbreak #: _____

Specimen Type*: Nasopharyngeal (NP) Swab Nasal Swab Dual Nasopharyngeal/Throat Swab Nasal Aspirate or Wash
 Bronchoalveolar Lavage Bronchial Wash Tracheal Aspirate Sputum Lung Tissue

PATIENT INFORMATION

Last Name*: _____

First Name*: _____

Medical Record # (MRN): _____

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

Sex: M F

Race: White Black/African American American Indian/Alaska Native Asian Native Hawaiian/Pacific Islander Other

Ethnicity: Not Hispanic or Latino Hispanic or Latino

Date of symptom onset (mm/dd/yy): _____

City, State, Zip: _____

County: _____

SURVEILLANCE DATA

Yes No Unknown

Was patient vaccinated against influenza? If yes: Injection Intranasal Date (mm/dd/yy): _____

Has patient recently been tested for influenza? If yes: Pos A Pos B Negative Date (mm/dd/yy): _____
 Testing method used (if known): _____

Does patient have Influenza-like illness? *Defined as a fever, cough, and/or sore throat of an unknown cause other than Influenza*

Has patient traveled in the last month?

If yes: Destination: _____ Mode of transportation: _____

Did patient receive antiviral treatment within the past month?

Was/is the patient hospitalized? If yes, was patient admitted to Intensive Care? Yes No

Was the patient admitted to Intensive Care for this condition?

Is the patient a healthcare worker?

Is the patient currently pregnant?

Does the patient reside in a congregate care setting?

ADDITIONAL COMMENTS