**INFLUENZA SURVEILLANCE: SPECIMEN SUBMISSION FORM**

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DO NOT USE THIS SPACE

**PRINT, LABEL OR STAMP:** ***COMPLETE ONE FORM PER SPECIMEN***

**1. Submitting Facility (Receives Test Result):** ☐ sentinel site

Facility / Laboratory Name *(required)*

Street Address

City, State Zip

Phone # Secure Fax #:

**2. Patient Info:**

Last Name, First Name

Street Address

City, State Zip

Patient ID: Phone #:

**3. Ordering Clinician/ Phone#:**

Clinician Name Phone number#

**4. Sex:** ☐ M ☐ F ☐ Other **Date of Birth:**_____

**5. Race:** (Check One)

☐ American Indian or Alaska Native ☐ Asian
☐ Black or African American ☐ White
☐ Native Hawaiian or Pacific Islander ☐ Other

**6. Ethnicity:** ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

DO NOT FREEZE KITS

**7. Test Requested:** ***(select one test per form )***

☐ Influenza Typing (PCR /Conventional)
☐ Respiratory Viral Panel *(Epi pre-approval required)*

**8. Collection Date:** *(required)*_____

**9. Source of Specimen:** ***(required; one form per specimen)***

☐ Nasopharyngeal swab (NP swab)- **[preferred specimen type]**
☐ Nasopharyngeal aspirate (NP aspirate)

Epi pre-approval required

☐ Endotracheal aspirate
☐ BAL (bronchoalveolar lavage)
☐ Sputum *(submit NP swab in addition to this specimen)*
☐ Lung tissue: post-mortem

**10. Culture:** *(complete for isolates submitted)*

Date of Initial Culture: _____

Date of Subculture:_____
Sample Treated ☐ Y ☐ N If yes, how:

**11. Additional Patient Information:**

Symptoms: ☐ fever ☐ cough ☐ sore throat ☐ Other (detail) Date of Symptom Onset *(required)*: _____

Is patient hospitalized or going to be hospitalized? ☐ YES ☐ NO
Is the patient pregnant? ☐ YES ☐ NO
Is patient a health care worker? ☐ YES ☐ NO

Other Laboratory Test Results: Date:_____ RESULT

☐ none ☐ A +
☐ Rapid Flu ☐ B +
☐ DFA ☐ A/B+
☐ PCR ☐ NEG

Seasonal vaccination: ☐ YES ☐ NO Date:_____ Sw H1N1 vaccination: ☐ YES ☐ NO Date:_____

MDPH Epi Consult (name):_____ (Contact the MA Immunization Program at 617-983-6800)