

COMMONWEALTH OF VIRGINIA – DEPARTMENT OF GENERAL SERVICES
 Division of Consolidated Laboratory Services
 600 N 5th St. Richmond, Va. 23219

Clinical Microbiology/Virology Request Form

Patient Information (Please Print)

1 **Name** JOHNSON BETTY M. **DOB** MM / DD / YYYY **Age** 55 M F **2** **3**

Pt Address PATIENT ADDRESS **City** _____ **State** _____ **Zip Code** _____

City/County of Residence _____ **4**

Medical Record/Chart/Accession# _____ **UNIQUE PATIENT IDENTIFIER FOR YOUR FACILITY HERE...** **Patient ID** _____ **OR HERE** **5**

Marital Status: single married separated divorced widowed unknown

Race: Black White Asian AI/AN NH/PI Other _____ **Ethnicity:** Hispanic/Latino Not-Hispanic/Latino

(check all that apply)

Submitter Information

Submitter Code # _____ **Site code** _____ **FIPS code** _____

Send Report to:

Submitter THE NAME OF YOUR FACILITY MUST MATCH NAME USED BY DCLS **Submitter Phone #** XXX-XXX-XXXX **6**

Submitter Address ADDRESS OF YOUR FACILITY AS IN DATABASE **City** _____ **State** _____ **Zip code** _____

Attending Clinician _____ **DOC**

Attending Clinician Phone # FACILITY - PHONE - NUM

District or PH Contact Phone # _____ Hospital

			Site Type		
<input type="radio"/> STD	<input type="radio"/> ATS	<input type="radio"/> DCJ	<input type="radio"/> FP	<input type="radio"/> GYN	<input checked="" type="radio"/> Priv Phys
<input type="radio"/> OB/prenatal care	<input type="radio"/> AHC	<input type="radio"/> Field	<input type="radio"/> IMM	<input type="radio"/> Job Corp	<input type="radio"/> Peds
<input type="radio"/> TB	<input type="radio"/> GMC	<input type="radio"/> CHC	<input type="radio"/> DTC	<input type="radio"/> Refugee	<input type="radio"/> SOI
<input checked="" type="radio"/> Hospital	<input type="radio"/> OCME	<input type="radio"/> Student HC		<input type="radio"/> Other	

8 **9**

Patient Medical History

Disease suspected/Diagnosed INFLUENZA **11** **12**

Signs/Symptoms

Asymptomatic Fever Respiratory Bloody sputum

Cough Productive cough Rash Vomiting

Diarrhea Stool + Blood Stool + Mucous Abdominal Pain

Apnea SIDS Sudden Unexplained Death

Administered _____

Other SORE THROAT

Recent Exposure (if applicable) Birds Ticks Mosquitoes

Other _____

Date of Onset: MM / DD / YYYY

Deceased Date: mm / dd / yyyy

Vaccine

(Please specify)
Vaccine Administration Date mm / dd / yyyy

Antibiotics/Anti-Viral Used _____

(Please specify)
Antibiotics/Antiviral Start Date mm / dd / yyyy

Special Information for Laboratorians

Outbreak Related no yes **Outbreak Number:** RES989FLUPSP16 **13**

Role of Patient (ex. food-handler, patron): _____

Other Information _____

*Complete information on back



INSTRUCTIONS FOR FILLING OUT LAB FORM FOR SENTINEL SURVEILLANCE OF SUSPECTED INFLUENZA CASES

FOR SENTINEL FLU SURVEILLANCE, ONLY THE FIELDS MARKED IN **RED** ARE REQUIRED. PLEASE WRITE CLEARLY.

1. PATIENT NAME, LAST NAME FIRST. THIS MUST EXACTLY MATCH THE NAME AS WRITTEN ON THE LAB SPECIMEN TUBE
2. PATIENT AGE / DOB MUST EXACTLY MATCH THE DATA AS WRITTEN ON THE LAB SPECIMEN TUBE
3. PLEASE INDICATE PATIENT GENDER
4. PLEASE FILL IN PATIENT'S ADDRESS OF RESIDENCE
5. YOUR FACILITY'S ID NUMBER FOR THE PATIENT; ONLY ONE IS NEEDED
6. PLEASE INDICATE PATIENT'S RACE / ETHNICITY
7. YOUR FACILITY'S NAME AND CONTACT DATA MUST MATCH THOSE GIVEN TO THE STATE LABORATORY FOR YOUR SITE. IF UNSURE, PLEASE CHECK WITH YOUR DISTRICT EPIDEMIOLOGIST.
8. NAME AND PHONE NUMBER OF RESPONSIBLE PHYSICIAN OR CLINICIAN
9. PLEASE INDICATE: SITE IS *EITHER* A PRIVATE PRACTICE **OR** HOSPITAL / ER / URGENT CARE CENTER
10. ALWAYS, INDICATE *FLU* OR *INFLUENZA*
11. PATIENT **MUST** HAVE FEVER plus COUGH **and** / **or** SORE THROAT IN ORDER TO MEET SURVEILLANCE CRITERIA; FEVER **MUST** BE MINIMUM OF 100° F
12. DATE OF ONSET: PLEASE INDICATE WHEN SYMPTOMS BEGAN
13. PLEASE DOCUMENT OUTBREAK ID: **RES989FLUPSP16**
14. PLEASE DOCUMENT DATE SPECIMEN WAS COLLECTED
15. PLEASE INDICATE VIRAL SPECIMEN
16. PLEASE INDICATE NP SWAB
17. ORGANISM SUSPECTED = INFLUENZA OR FLU