DCLS

INSTRUCTIONS FOR SPECIMEN LABELING

SENTINEL INFLUENZA SURVEILLANCE ONLY

1	NAME_____
2	HOSPITAL NO._____
3	AGE / DOB_____ ROOM NO._____

1. LAST NAME, FIRST NAME, MIDDLE INITIAL. THIS INFO MUST **MATCH** THE SPECIMEN COLLECTION FORM *EXACTLY*

2. **NAME** OF YOUR FACILITY

3. PLEASE INDICATE PATIENT **DOB**, FORMATTED MM/DD/YYYY