Influenza Specimen Laboratory Submission Form

Government of Guam
Department of Public Health & Social Services
123 Chalan Kareta
Mangilao, Guam 96913-6304

GPHL ACCESSION NUMBER

DATE RECEIVED BY GPHL

Influenza Specimen Laboratory Submission Form

USE FOR RESPIRATORY SPECIMENS COLLECTED FOR INFLUENZA SURVEILLANCE ONLY

PLEASE NOTE THAT ALL ITEMS ARE REQUIRED

NAME AND ADDRESS OF PHYSICIAN/SCHOOL/FACILITY: (SUBMITTER)

LABORATORY PERFORMING INFLUENZA RAPID TESTING:

CLINICAL DIAGNOSIS
INFLUENZA

CATEGORY OF AGENT SUSPECTED
VIRUS

LABORATORY EXAMINATION REQUESTED

SPECIFIC AGENT SUSPECTED
INFLUENZA VIRUS

PATIENT IDENTIFICATION

LAST NAME & MIDDLE INITIAL | FIRST NAME

ADDRESS

VILLAGE | ETHNICITY

TELEPHONE NO | OCCUPATION

STATUS
- ☐ Guam Resident
- ☐ Tourist

DATE OF BIRTH: (MM/DD/YYYY)

RACE:

SEX:
- ☐ Male
- ☐ Female

HOSPITALIZATION REQUIRED?
☐ Yes ☐ No

HOSPITAL ADMIT DATE: (MM/DD/YYYY)

DATE OF ONSET: (MM/DD/YYYY)

CHART NUMBER:

SPECIMEN INFORMATION

TYPE OF SPECIMEN
- ☐ NASAL SWAB (Preferred)
- ☐ NASOPHARYNGEAL SWAB
- ☐ NASAL ASPIRATE
- ☐ NASAL WASHING

DATE OF COLLECTION (MM/DD/YYYY)

SCREENING TEST ☐ DONE ☐ NOT DONE

DATE OF TESTING (MM/DD/YY)

RAPID TEST KIT USED: (PLEASE INDICATE)
- ☐ QUICKVUE INFLUENZA A/B
- ☐ QUICKVUE INFLUENZA A+B
- ☐ IFA
- ☐ DIRECTIGEN FLU A
- ☐ DIRECTIGEN FLU B
- ☐ OTHER (SPECIFY)

RAPID TEST RESULT: (PLEASE INDICATE)
- FLU A ☐ POSITIVE ☐ NEGATIVE
- FLU B ☐ POSITIVE ☐ NEGATIVE

SPECIMEN REFERENCE NUMBER | DATE REPORTED | TECH INITIALS

DO NOT WRITE BELOW THIS LINE
DEPARTMENT OF PUBLIC HEALTH USE ONLY

1. CLINICAL SIGNS AND SYMPTOMS

- ☐ FEVER (Maximum Temp _____ °C/°F)
- ☐ COUGH
- ☐ SORE THROAT
- ☐ BODY ACHES
- ☐ FATIGUE
- ☐ VOMITING
- ☐ CHEST PAIN
- ☐ NAUSEA
- ☐ DIARRHEA
- ☐ HEADACHE
- ☐ SHORTNESS OF BREATH
- ☐ EAR ACHE
- ☐ RUNNY NOSE
- ☐ ABDOMINAL PAIN
- ☐ CHILLS
- ☐ SINUS CONGESTION
- ☐ CONJUNCTIVITIS

2. MEDICAL CONDITION

- ☐ DIABETES
- ☐ ASTHMA
- ☐ EMPYSEMA
- ☐ HEART DISEASE
- ☐ MMUNE SUPPRESSION
- ☐ HIV INFECTION
- ☐ PREGNANCY
- ☐ OBESITY (BMI) _____
- ☐ OTHER _____

3. LIST ANY TRAVELLING WITHIN THE 7-DAY PERIOD PRIOR TO ONSET OF ILLNESS (Place & Dates):

4. PATIENT EVER RECEIVED INFLUENZA VACCINE?

☐ YES ☐ NO

DATE OF LAST VACCINATION: (MM/DD/YY)

MANUFACTURER NAME:

LOT NUMBER:

5. ANTIVIRAL THERAPY

NAME OF MEDICATION	DOSAGE	DATE

6. OTHER INFORMATION:

(See Specimen Collection Instructions At The Back)