



## Dallas County Health and Human Services Influenza Specimen Submission and Test Result Form

**\*Required information: failure to provide information may result in an inability to test or a delay**

*If from outside of Dallas County, please submit specimens to DCHHS through your local or regional Health Department*

CLIA#45D0672012	2377 N. Stemmons Freeway, Dallas, TX 75207	Lab NBT #:	<i>(For lab use only)</i>
PATIENT	*Patient Last Name: _____ *First Name: _____ *Date of Birth (MM/DD/YYYY): _____ Patient ID # / Medical Record #: _____ *Address: _____ *City: _____ *State: _____ *County: _____ Zip: _____ *Phone #: _____ Cell #: _____		
SUBMITTER	*Physician /Hospital / Lab / Clinic Name: _____ *Contact Last Name: _____ *First Name: _____ Address: _____ City: _____ State: _____ Zip: _____ *Phone #: _____ *Fax #: _____ Pager #: _____		
SPECIMEN	*Date of Collection (REQUIRED): _____ *Influenza Rapid Test Results: <input type="checkbox"/> A+ <input type="checkbox"/> B+ <input type="checkbox"/> Positive, type not differentiated <input type="checkbox"/> Negative <input type="checkbox"/> Not tested *Specimen: <input type="checkbox"/> Throat Swab <input type="checkbox"/> NP Swab <input type="checkbox"/> Nasal Swab <input type="checkbox"/> Wash/Aspirate: Source _____ <input type="checkbox"/> Other: _____		
EPIDEMIOLOGY	Date of Symptom Onset: _____ Yes <input type="checkbox"/> No <input type="checkbox"/> *Is the patient hospitalized with severe respiratory illness? Yes <input type="checkbox"/> No <input type="checkbox"/> *Has the patient died with severe respiratory illness? Yes <input type="checkbox"/> No <input type="checkbox"/> *Is the patient pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/> *Is the patient a health care worker, child care worker, or other occupation that could spread infection to those at high risk for severe complications? If yes, list the employer (name and address): _____ Yes <input type="checkbox"/> No <input type="checkbox"/> *Does the patient attend school or child care, live in a congregate setting (e.g., LTCF, group home, homeless shelter, etc.)? If yes, please list facility name _____ Yes <input type="checkbox"/> No <input type="checkbox"/> *Sentinel Surveillance Site Specimen		
	Comments:		

**LABORATORY** *(For DCHHS Lab Use Only - DO NOT Write Below)*

*Negative results do not preclude influenza virus infection and should not be used as the sole basis for treatment.*

**INFLUENZA PCR RESULTS:**

- No influenza A or B Virus Detected     No influenza A virus detected only  
 No influenza B Virus detected only     Specimen unsatisfactory due to: \_\_\_\_\_  
 Influenza Virus detected:     Influenza A     Influenza B

**INFLUENZA A/B SUBTYPE PCR RESULTS:**

- Influenza 2009 A(H1N1)pdm     Influenza A/H3 Seasonal     Influenza A/H1 Seasonal     Influenza A/H5  
 Influenza A/H7     Influenza A/H3N2(v)     Other: \_\_\_\_\_

Specimen Received by DCHHS Lab:  Frozen     Cold     Room Temperature    Date Checked In: \_\_\_\_\_  
 Specimen sent to CDC/DSHS:  No     Yes Date: \_\_\_\_\_ Results Received Date: \_\_\_\_\_  
 Date DCHHS Results Faxed/reported: \_\_\_\_\_     Date DCHHS Results Amended: \_\_\_\_\_