INFLUENZA PCR TEST REQUEST FORM

UNIFIED STATE LABORATORIES: PUBLIC HEALTH
4431 SOUTH 2700 WEST
TAYLORSVILLE, UTAH 84119
TELEPHONE: (801) 965-2400, (801) 965-2561
FAX: (801) 965-2551
http://health.utah.gov/lab/microbiology

FOR USLPH USE ONLY

LAB#:

DATE STAMP:

****NOTE: MANDATORY SECTIONS MUST BE FILLED OUT FOR SAMPLES TO BE TESTED****
Please print clearly for accuracy. Dark gray sections are for USLPH use.

CLINICAL/EPIDEMIOLOGIC CRITERIA FOR TESTING (MANDATORY)

Indicate Origin of Sample, (CHOOSE 1):

HOSPITALIZED (with Influenza-Like Illness) [ ]YES [ ]NO

SENTINEL SITE [ ] YES [ ]NO

OTHER (ie cluster investigation) [ ]YES [ ]NO

Cluster location:_____
Other reason for testing: _____
_____

PATIENT/SPECIMEN INFORMATION. (MANDATORY FIELDS IN BOLD)

PATIENT NAME (Last, First):

Patient ID # (optional):	**DATE OF BIRTH** (mm/dd/yy) _____/_____/_____	**AGE:**	**SEX:** M F

PATIENT COUNTY OF RESIDENCE: (NOT COUNTRY) _____

PATIENT STATE OF RESIDENCE: _____

PROVIDER INFORMATION Provider Code (required):
For provider code, call USLPH 801-965-2400

SPECIMEN COLLECTION DATE (mm/dd/yy)
_____/_____/_____

SPECIMEN SOURCE/SITE (CHOOSE 1)**:**

[ ] Nasopharyngeal swab (NPS)
[ ] Nasal swab (NS)
[ ] Throat swab (TS)
[ ] Combined nasopharyngeal-throat swab (NPS/TS)
[ ] Nasal aspirate (NA)
[ ] Nasal washes (NW)
[ ] Broncheoalveolar lavage (BAL)
[ ] Bronchial aspirate (BA)
[ ] Bronchial wash (BW)
[ ] Endotracheal aspirate (EA)
[ ] Endotracheal wash (EW)
[ ]Tracheal aspirate (TA)
[ ] Lung tissue
[ ] Culture isolate (source):_____

Optional Information:
Physician: _____
Provider Phone: _____
Provider Email: _____
Secure Fax #: _____

MOLECULAR TESTS:

[X] Influenza A & B Virus PCR (with H subtyping)

FOR LAB USE ONLY

Date	_____	Date	_____
InfA	_____	InfA	_____
InfB	_____	H1	_____
RP	_____	H3	_____
Tech	_____	pdm A	_____
		pdm H1	_____
		Tech	_____

Revised September 14, 2010