

INFLUENZA PCR TEST REQUEST FORM

UNIFIED STATE LABORATORIES: PUBLIC HEALTH
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<http://health.utah.gov/lab/microbiology>

FOR UPHL 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 UPHL use.

CLINICAL/EPIDEMIOLOGIC CRITERIA FOR TESTING (MANDATORY)

Indicate Origin of Sample, (CHOOSE 1):

HOSPITALIZED (with Influenza-Like Illness)

SENTINEL SITE

**NOT HOSPITALIZED; NOT SENTINEL
BUT PRE-APPROVED BY UDOH EPI***

YES NO

YES NO

YES NO

Approved by: _____
 *Pre-approved samples are authorized through
 UDOH Epidemiology 801-538-6191.

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 UPHL 801-965-2400

SPECIMEN COLLECTION DATE (mm/dd/yy)



_____/_____/_____

SPECIMEN SOURCE/SITE (CHOOSE 1): (*NOTE: CDC/FDA have cleared all the following to be tested)

Nasopharyngeal swab (NPS)

Nasal swab (NS)

Throat swab (TS)

Combined nasopharyngeal-throat swab (NPS/TS)

Nasal aspirate (NA)

Nasal washes (NW)

Bronchoalveolar 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:

Influenza A & B Virus PCR (with H subtyping)

Novel Influenza A (H1N1) rule out

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Inf A _____

sw Flu A _____

sw H1 _____

RP _____

H1 _____

H3 _____

Inf B _____