NEBRASKA PUBLIC HEALTH LABORATORY
UNIVERSITY OF NEBRASKA MEDICAL CENTER
981180 NEBRASKA MEDICAL CENTER OMAHA, NEBRASKA 68198-1180
TOLL FREE: 866.290.1406 PHONE: (402) 559-2440 FAX: (402) 559-9497
WWW.NPHL.ORG

SPECIAL INFLUENZA MICROBIOLOGY REQUISITION

PATIENT LAST NAME **FIRST NAME** **MI**

Laboratory Name and Address
_____
_____
_____

Telephone:
Fax Number:

Contact Name (printed):

Test approved by: Safranek/Williams 2009

DATE OF BIRTH **AGE** **SEX**
/ / M / F

ADDRESS **APT**

CITY **STATE** **ZIP**

COUNTY CODE **STATE CODE** **SURVEILLANCE SITE**

PHYSICIAN'S NAME **PHONE #**

COLLECTION DATE **COLLECTION TIME**
/ / **AM / PM**

ID / CHART NUMBER (NUMBER WILL APPEAR ON REPORT)

Clinical Diagnosis:_____**ICD 9 Code:**_____

Race ___White ___Black ___Native American ___Asian/Pacific Islander ___Unknown ___Other_____

Ethnicity ___Hispanic ___Non-Hispanic ____Unknown

Source: ____Nasopharyngeal Swab _____Nasopharyngeal Washing _____Other _____

Virology

___ Influenza Surveillance Testing - RT-PCR/Respiratory Viral Panel

Is this patient hospitalized?	**____YES**	**____NO**	**___UNK**
Does the patient have a chronic underlying condition?	_____YES	_____NO	**___UNK**
Is this patient pregnant?	_____YES	_____NO	**___UNK**
Is this patient part of an outbreak?	_____YES	_____NO	**___UNK**

Rapid influenza antigen detection test kit performed: _____YES _____ NO
Influenza A test results: ____Positive ____Negative
Influenza B test results: ____Positive ____Negative

Name of rapid antigen test kit used: _____

If Rapid Influenza A negative, Public Health Staff Authorization must be obtained for submission to NPHL.

Name of Public Health Staff: _____