Influenza Testing

All fields MUST be completed. Ship sample with an ice pack in a rigid shipping container.

For Lab Use Only

MS Public Health Laboratories
Main Lab - 570 East Woodrow Wilson
Jackson, Mississippi 39216
Phone - 601-576-7582

Lawson Street Lab - 3152 Lawson Street
Jackson, Mississippi 39213
Phone - 601-981-6158

Patient Information

Name _____

Date of Birth _____ SSN _____

Race ____ Sex____ Med Record No._____

Address _____

City _____ State _____ Zip Code _____

County _____

Patient History Is Required

Date of Onset _____

Cough ❑ Fever ≥ 100 F ❑ Sore Throat ❑ Other _____

Pregnant Yes ___ No ___ Hospitalized Yes ___ No ___

Flu Vaccination Status: Received: Yes ___ No ___

If yes, Date received _____

Rapid Kit Test Pos ____ Neg ____ Date_____

Travel History:_____

Submitter Information

Physician _____

Institution _____

Address _____

_____

Contact Name _____

Daytime Phone # _____

After Hours Phone # _____

Sample Type (check one)

Throat ❑ Nasopharyngeal ❑

Other _____

Date of Collection: _____

Program: Epidemiology

Place Barcode Label Here.

Mississippi State Department of Health FORM 930, revised August 2009

Influenza Testing, REQ-930 Instructions

PURPOSE

To provide health care providers with a means of influenza specimen and/or sample identification as well as other pertinent information necessary for Real Time PCR laboratory molecular analysis, patient's record, etc.

EXPLANATION AND DEFINITION

All blanks on the form should be completed. This form should ONLY be used for Influenza testing by RT- PCR.

For Lab Use Only section: Should remain blank

Patient Information

- Name and demographics must be filled in completely.

Patient History

- Date of Onset: Fill in the date the symptoms were reported.

Signs and Symptoms

- Check the appropriate box for all reported symptoms and include any not listed in the 'other' blank. Indicate pregnancy status and whether patient is hospitalized.

Flu Vaccination Status

- Place a check mark beside the appropriate response.
- If yes, write the date that the vaccination was given in the blank.
- Rapid Kit Test results, <u>if performed</u>, should be checked with date of testing.

Travel History

- 2 weeks before the onset of symptoms

Submitter Information

- Write the name of the physician submitting the specimen in the space provided.
- Write the institution submitting the specimen in the space provided.
- Write the address of the institution submitting the specimen in the space provided.
- Write the names that need to be contacted in the space provided.
- Write the daytime and after hours phone numbers for the contact person listed.

Sample type

- Place a check mark beside the appropriate response or specify specimen type.
- Fill out the date the specimen was collected in the space provided.

OFFICE MECHANICS AND FILING

This form is multi–copy and requires the use of a ball point pen. Patients' name should be permanently affixed to every viral transport tube in such a manner that accidental or intentional separation of laboratory forms and specimen will not result in loss of specimen identity. Each specimen should have a form attached. Do not submit more than one specimen with each form.

Reports from the laboratory are mailed to the physician, health department, or other agency given in the "Submitter Information" section of the form.

RETENTION PERIOD
The laboratory retains a copy of the original request for 2 years in accordance with federal regulations.

The yellow copy may be placed in the patient's medical record and retained according to agency policy for the record type.