

Influenza Lab Specimen Submission Form

DEPARTMENT OF HEALTH  
PUBLIC HEALTH LABORATORY  
201 South Monroe  
Little Rock, AR 72205

Patient Information (** Required fields)					Submitter Information (** Required fields) -----Submitter MUST Provide ----- -----Complete and Accurate Contact Information-----		
Patient's Last Name**		First Name**		Middle initial	Submitter ID or #**	Submitter's Name**	
Address**					Submitter's Address**		
City**		State**	Zip**	County of Residence**			
DOB(mm/dd/yy)**	Sex** <input type="radio"/> Male <input type="radio"/> Female		Race** <input type="radio"/> White <input type="radio"/> Black or African American <input type="radio"/> American Indian/Native Alaska <input type="radio"/> Asian <input type="radio"/> Native Hawaiian/Pacific Islander <input type="radio"/> Other		City**	State**	Zip**
Ethnicity** <input type="radio"/> Hispanic <input type="radio"/> Non-Hispanic <input type="radio"/> Unknown					Phone	FAX**	
Patient Information					Requestor Information (**Required)		
Is Patient Pregnant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown					Requestor's Name**		
If Yes, Expected Date of Delivery? _____ / _____ / _____ MM DD YYYY					Test / Specimen (**Required)		
Health Care Worker? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown					<b>Test Requested**</b> <input type="radio"/> Influenza by PCR		
Patient Hospitalized? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown					<b>Specimen Type**</b> <input type="radio"/> Nasopharyngeal Swab <input type="radio"/> Nasal Swab <input type="radio"/> Throat Swab <input type="radio"/> Nasal Aspirate <input type="radio"/> Dual Nasal/Throat Swab		
Vaccinated Against Flu? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown					_____/_____/____ Date Collected ** MM DD YYYY		
Recent travel outside U.S.? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown					____:____ Time Collected** HH MM		
Was rapid test performed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown					<b>SYMPTOMS (**Required)</b>		
If Yes, indicate result _____					Date of Onset**: ____/____/____ MM DD YYYY		
Patient has underlying medical conditions? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown					Symptoms** <input type="checkbox"/> Fever > 100 F <input type="checkbox"/> Cough <input type="checkbox"/> Sore Throat <input type="checkbox"/> Other (specify) _____		

Notes: This form is for PRIVATE submitters only.  
 = Select only ONE;  = Check ALL that apply; \*\* = Required fields; For times, use Military format HH:MM