

**REQUISITION FOR INFLUENZA AND RESPIRATORY VIRUS TESTING
 DURING PANDEMIC**

Do not test if patient has a mild influenza-like illness, unless indicated by risk information

Personal Health Number (PHN) or unique ID number if no PHN		Patient. Hospital. #		Hospital & location (ward, clinic)				ProvLab use only <input type="checkbox"/> 789 <input type="checkbox"/> 8002 <input type="checkbox"/> 8350 EI number for outbreak
<input type="checkbox"/> M <input type="checkbox"/> F	Patient Legal Name (Last) (First) (middle)			D O B	DD	MM	YYYY	
Patient Address		City	Prov	Postal code				
Submitter				Send copy to				
Physician / Nurse Practitioner (Last Name) (First Name)				Last and First name				
Reporting Address				Reporting Address				
Physician code		Report Location code						

Date\Time specimen collected: ___ dd ___ mm ___ yyyy **TIME (24 h):** _____

Specimen Type: Autopsy (773) Yes No

SWAB (14) <input type="checkbox"/> Nasopharyngeal (184) <input type="checkbox"/> Throat (275)	FLUID \ ASPIRATE (4) <input type="checkbox"/> Nasopharyngeal (184) <input type="checkbox"/> Auger suction (16) <input type="checkbox"/> Pleural Fluid (226): <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Endotracheal (80) <input type="checkbox"/> BAL (30): ORUL ORML ORLL OLUL OLLL <input type="checkbox"/> Bronchial wash (31): ORight Lung OLeft Lung	TISSUE (15) Anatomical site: _____
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For information related to specimen collection or type, visit www.provlab.ab.ca

ADDITIONAL INFORMATION: CHECK all applicable box(es).

INPATIENT <input type="checkbox"/> Pending hospital admission <input type="checkbox"/> Inpatient <input type="checkbox"/> ICU \ PICU \ NICU <input type="checkbox"/> Critical care	OUTPATIENT <input type="checkbox"/> Community Clinic <input type="checkbox"/> Hospital Clinic <input type="checkbox"/> ER not for admission	Clinical information: Check all that apply <input type="checkbox"/> Chronic cardiopulmonary disorders (873) (e.g., asthma, COPD, bronchopulmonary dysplasia, congestive heart failure) <input type="checkbox"/> Diabetes mellitus (89) <input type="checkbox"/> High body mass index \ Obesity (872) <input type="checkbox"/> Immunocompromised (298) (e.g., transplant recipient, on chemotherapy\ immunosuppressives, immunodeficiency state) <input type="checkbox"/> Pregnancy \ Postpartum within 4 weeks (238) <input type="checkbox"/> Renal Dialysis (752) <input type="checkbox"/> None (316) <input type="checkbox"/> Other _____ (specify)
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Other history:

Onset of illness: ___ dd ___ mm ___ yyyy

Travel within last 2 weeks to: _____ (state country), returned on ___ dd ___ mm

Patient received: 2009/10 Seasonal Flu Vaccine (874) Pandemic Flu Vaccine (875) None (876) Unknown (877)

Antiviral history: Oseltamivir (878) Zanamivir (879) **Start date:** ___ dd ___ mm