Wyoming Public Health Laboratory
208 S. College Drive
Cheyenne, WY 82007
307-777-7431

REQUISITION FOR INFLUENZA CULTURE

INSTRUCTIONS

- Specimens should be collected within 3 days of symptom onset
- Specimens should be collected & shipped according to attached protocol
- Specimens must arrive at the lab within 48 hours of collection
- Maintain Specimen at **2-4° C** and ship on COLD PAK to the WPHL with the completed form.
- Use Fed Ex account 2987-4494-5 for shipping flu cultures only.

(Please print clearly with black ballpoint pen.)

Patient Name (Last) **(First)** **(MI)**	**DOB** / /	**Gender**
Patient Address **Phone** ( )	**Age**	☐ **Male** ☐ **Female**

Hispanic: ☐ **Yes** ☐ **No** ☐ **Unknown**

Race: ☐ **White** ☐ **Black** ☐ **Asian/Pacific Islander** ☐ **Native American** ☐ **Other** ☐ **Unknown**

Submitting Laboratory Name and Address (return address)	**Phone Number** ( ) **Fax Number** ( )

Attending Physician Name _____

COMPLETE ENTIRE SECTION BELOW TO ENSURE CORRECT TESTING INFORMATION

Date of onset of illness: _____/_____/_____

Rapid Flu Test Results:

☐ **Negative** ☐ **No rapid test performed**

☐ **A positive** ☐ **B positive**

☐ **A&B positive (Not Differentiated)**

SAMPLE TYPE	**DATE COLLECTED**
☐ **Nasopharyngeal swab**	_____/_____/_____
☐ **Nasal swab**	_____/_____/_____
☐ **Nasal wash/aspirate**	_____/_____/_____
☐ **Other**_____	_____/_____/_____

Was patient hospitalized? ☐ **Yes** ☐ **No**

If yes: Hospital _____

Date Admitted _____/_____/_____

Flu Vaccination ☐ **Yes** ☐ **No**

Patient Symptoms

☐ **Fever** ☐ **Sore throat**

☐ **Headache** ☐ **Nasal congestion**

☐ **Dry cough** ☐ **Shortness of breath**

☐ **Body Aches** ☐ **Diarrhea**

☐ **Vomiting** ☐ **Other** _____

Patient Name: _____ DOB: _____

If yes, date received: _____/_____/_____

Nasal Vaccination ☐ **Yes** ☐ **No**

Patient's weight _____ **kg or lbs**

Patient's height _____ **cm or ft/in**

☐ **Travel outside USA Country:** _____

Date of Travel _____/_____/_____

Does the patient have any of the following?

☐ **Asthma**

☐ **Other chronic lung disease**

☐ **Cancer**

☐ **Neurological disease**

☐ **Kidney disease**

☐ **Chronic heart /Circulatory disease**

☐ **Metabolic disease (including diabetes mellitus)**

☐ **Other Chronic Disease** _____

Did the patient receive antiviral medication?

☐ **Yes** ☐ **No** ☐ **Unknown**

If yes, complete the table below

Drug	Start Date	Number of days	Dosage
Tamiflu (Oseltamivir)			
Relenza (Zanamivir)			
Rimantidine			
Amantadine			
Other_____			

Does the patient work in a health care facility/setting?

☐ **Yes** ☐ **No** ☐ **Unknown**

If yes: Name of facility/setting

_____

Pregnant?

☐ **Yes** ☐ **No** ☐ **Unknown** ☐ **Not Applicable**

If yes, how many weeks _____

Does the patient attend school?

☐ **Yes** ☐ **No** ☐ **Unknown**

If yes: School _____

Does the patient attend daycare?

☐ **Yes** ☐ **No** ☐ **Unknown**

If yes: Daycare _____