STATE LAB USE ONLY	
Sentinel ID #	
Lab ID #	
Received	
Reported	
Results	
Tech	

Wyoming Department of Health
Public Health Laboratory
208 S. College
Cheyenne, WY 82002
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** ☐ **Male** ☐ **Female**
Patient Address **Phone** ( )	**Age**	

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**

If yes, date received: _____/_____/_____

Nasal Vaccination ☐ **Yes** ☐ **No**

Patient Symptoms

☐ **Sore throat** ☐ **Fever (≥ 100.0 °F)**

☐ **Headache** ☐ **Nasal congestion**

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

☐ **Body Aches** ☐ **Diarrhea**

☐ **Vomiting** ☐ **Other** _____

Patient Name: _____ DOB: _____

Highest fever at home _____° F or ☐ N/A

Date taken: _____/_____/_____

Highest fever during healthcare visit _____° F

☐ Travel outside USA Country: _____

Date of Travel _____/_____/_____

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)			
Rimantadine			
Amantadine			
Other_____			

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 _____

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 _____

Patient's weight _____ kg or lbs

Patient's height _____ cm or ft/in

Part of a suspected cluster or outbreak?

☐ Yes ☐ No ☐ Unknown

If yes, list other possible cases

_____

_____

_____

Level (s) of medical care *(check all that apply)*

☐ Clinic visit

☐ Emergency Department/ER visit

☐ In-patient admission (hospitalized patient)

☐ Intensive Care Unit (ICU)

☐ Other _____