

LABORATORY SERVICES REQUEST FORM INFLUENZA SURVEILLANCE – SPECIMEN REQUEST FORM

INSTRUCTIONS FOR USING FILLABLE FORMS: In Acrobat Reader, please complete this form, then SAVE AS pdf to your hard drive. Print out the form and send to ESR with your specimen. You can email your form to virology@esr.cri.nz

PATIENT INFORMATION *These data fields must be completed for specimen matching and identification as well as for epidemiological purposes*

NHI number: _____ Sex: _____ Ethnicity: _____

Surname: _____ First name: _____

DoB: _____ Occupation: _____

DHB: _____ Ward: _____ Dr/Requestor: _____

ESR USE ONLY

Attach
label here

Comments:

CLINICAL INFORMATION *Please select appropriate responses and provide relevant information*

Onset date: _____ Foreign travel (specify country): _____

Animal contact: NZ Overseas If yes, specify animal contact: _____

Symptoms/Other details: _____

INFLUENZA VACCINATION AND ANTIVIRALS

Has the patient been vaccinated for influenza in the same year as the onset of influenza-like illness?

Yes No Don't know

If known, specify date of last influenza vaccination:

Date: _____

Has the patient had antiviral (eg: Tamiflu) medication?

Yes No Don't know

If yes, specify name, date and duration of antiviral medication: _____

Has any of the patient's household member(s) had antiviral medication?

Yes No Don't know

If yes, specify name, date and duration of antiviral medication: _____

NAME AND ADDRESS FOR REPORTING

Name: _____

Contact: _____

Phone: _____

Email: _____

Other (specify): _____

SPECIMEN STORAGE /TRANSPORT HISTORY

Referring laboratories must complete this section to comply with IANZ standards. Please indicate the specimen storage condition and transportation prior to sending to ESR.

	Ambient	Chilled	Frozen	Time
Stored:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	for _____
Transported:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Sample sent to:

NCBID – Wallaceville: 66 Ward Street, Upper Hutt

SPECIMEN INFORMATION

Date collected: _____ Date sent to lab: _____

SPECIMEN TYPE SITE:

Nasopharyngeal swab

Throat swab

Nasal swab

Other specimen type (specify): _____

ESR USE ONLY

	Ambient	Chilled	Frozen	A	R
Received:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

TESTS REQUIRED Routine URGENT

Influenza virus detection/subtyping by PCR

Influenza virus antigenic strain typing/subtyping

Antiviral susceptibility

Other (specify): _____

RESET FORM