



Novel Influenza A (H1N1) Detection

Patients must have a high fever and respiratory symptoms without other apparent cause.

Specimen Type:

Nasopharyngeal swab (M4-RT Preservative)

Date Collected:

____ / ____ / ____
mm dd year

Test Requested:

Novel Influenza A (H1N1) detection.

Patient: _____

Date of Birth _____ / _____ / _____
Last First SSN #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Gender: Female Male

Patient ID #: _____

Clinician: _____ Clinician ID #: _____

Please print Last First

Phone: (____) _____

Clinician Signature: _____

Please select one of the following testing options:

Hospitalized Patient:

Novel H1N1 test request will be sent to University of Iowa Hygienic Laboratory or Illinois Department of Public Health Laboratory for Novel H1N1 detection by PCR at no charge.

Non-Hospitalized

Patient: Novel H1N1 test request is presently sent through Mayo Medical Laboratory for H1N1 detection by PCR for a charge.

Mayo's price for H1N1 PCR testing is \$323, and is subject to change.

Other: If patient testing is requested by a State or County Health Authority, please provide the name of the requesting agency and reason for testing in the comment section of this form. Novel H1N1 test requests will be sent to University of Iowa Hygienic Laboratory or Illinois Department of Public Health Laboratory for Novel H1N1 detection by PCR at no charge.

Patient History:

Clinical Diagnosis: _____ Date of Onset: ____ / ____ / ____
Mm dd year

Hospitalized: No

Yes Hospital: _____

(Note: Emergency Department patients who are not admitted to the hospital are considered non-hospitalized patients by the State Laboratories.)

Fever: _____ °F (in office)

Signs & Symptoms

- Cough (Duration ____ days)
- Pharyngitis
- Conjunctivitis
- Vesicular Rash / Lesion
- Headache
- Maculopapular Rash
- Photophobia
- Meningitis / Encephalitis
- Myalgia
- Myocarditis / Pericarditis
- Diarrhea

International Travel: ____ / ____ / ____
mm dd year

Influenza Vaccination: ____ / ____ / ____
mm dd year

- Live (FluMist)
- Killed (Injection)

Started Antibiotic / Antiviral: ____ / ____ / ____
mm dd year

Type: _____

COMMENTS: _____

