CITY AND COUNTY OF SAN FRANCISCO
PUBLIC HEALTH LABORATORY
101 Grove Street, Room 419
San Francisco, CA 94102
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CLIA ID # 05D0643643

For Laboratory Use Only

____________________ Laboratory Number   ____________________ Date/Time Received

INFLUENZA (FLU) SPECIMEN SUBMISSION FORM

PLEASE ATTACH PRE-PRINTED LABEL or PRINT CLEARLY

Patient's Name: ____Gender: ____DOB: ____________Race/Ethnicity:____________
Last, First

Address: ____ Phone: ______________________

City / State:____ Zip Code: _____________________

Submitted By (Hospital)____________________________________ **Requesting Clinician**: __________________________________
(Clinic)
MRN#: __________________________ Phone Number: ________________________ Fax Number: _________________________

CHECK BOTH SOURCE & CRITERIA FOR TESTING & INDICATE DATE COLLECTED

DATE SPECIMEN COLLECTED: ___________________ **(Collect specimen within 5 days of symptom onset.)**

SPECIMEN SOURCE:

☐ Nasopharyngeal Swab ☐ Nasopharyngeal Aspirate ☐ Nasal Wash ☐ Nasal Aspirate

☐ Oropharyngeal (Throat) Swab ☐ Nasal Swab ☐ Other______________________

VIROLOGY

☒ **Influenza PCR Screen**

CRITERIA FOR TESTING (REQUIRED):

Submit respiratory specimens ONLY from patients who meet one of the criteria below:

- ☐ Patients who have an undiagnosed severe acute febrile respiratory illness requiring hospitalization.
  Symptom Onset Date: ___/___/____ ☐ Unknown
- ☐ Probable or confirmed influenza **Symptom Onset Date:** ___/___/____ ☐ Unknown
- ☐ Influenza-like illness: fever **≥37.8°C (100°F), AND sore throat or cough**
  ☐ Fever (≥37.8°C/100°F) Max Temp_________ ☐C ☐F
  AND: ☐ Cough ☐ Sore Throat ☐ Other _________________
  Symptom Onset Date: ___/___/____ ☐ Unknown

AND who are at least one of the following (check all that apply):

- ☐ Died
- ☐ Admitted to the Hospital? ICU? ☐Yes ☐No
  Date admitted ___/___/____ Date Discharged ___/___/____ ☐ Still Hospitalized?
- ☐ Live in a Long Term Care Facility
- ☐ Recent travel (within ≤ 10 days of illness onset) to a country where variant or novel flu has been detected
- ☐ Recent contact (within ≤ 10 days of illness onset) with a confirmed or probable case of variant or novel flu

Specimens not meeting above criteria will not be tested.

If symptom and exposure information is incomplete, this form will be faxed back to you. Please provide fax back number.

Fax Number: _______________________ **Phone Number:** ________________________

Report all fatal cases of suspected or confirmed Influenza to SFDPH Disease Control (415) 554-2830

Revised 10/26/17