



Request for Real-Time RT-PCR Influenza Testing

LAB # (Lab use only)
Date received (Lab use only)

Patient Information – Required. Fill out form completely. Please print plainly.

Revised 10/2011

Last name:		First name:		MI:
Chart number or other ID:		Male <input type="checkbox"/> Female <input type="checkbox"/>	DOB:	Age:
County of Residence:		State of Residence:	Zip:	
Type of Specimen: <input type="checkbox"/> Nasopharyngeal swabs <input type="checkbox"/> Nasal swabs <input type="checkbox"/> Throat swabs <input type="checkbox"/> Nasal aspirates <input type="checkbox"/> Nasal washes <input type="checkbox"/> Dual nasopharyngeal/throat swabs <input type="checkbox"/> Bronchoalveolar lavage <input type="checkbox"/> Bronchial wash <input type="checkbox"/> Tracheal aspirate <input type="checkbox"/> Other:				
Name & Address of Hospital:				
Name of Physician:				
Date of Onset:		Date of Admission:		

Date Collected:	Time: _____ AM / PM
-----------------	---------------------

Mail Results To:

Provider:		Attention:		
Address:		City:	State:	Zip:
Phone:		Fax:		
<input type="checkbox"/> Fax requested. (Reports are mailed unless a FAX report is requested.)				

Comments: