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

Wyoming Department of Health
Public Health Laboratory
208 South College Drive
Cheyenne, WY 82002
307-777-7431

REQUISITION FOR ENTEROVIRUS TESTING

INSTRUCTIONS FOR INFLUENZA TESTING

- 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 5 days of collection
- Maintain Specimen at **2-4 ˚C** and ship on COLD PAK to the WPHL with the completed form

(Please print clearly with black ballpoint pen.)

Patient Name (Last) **(First)** **(MI)**	**DOB** / /	**Gender** ☐ **Male** ☐ **Female**
Patient Address **Home Phone** ( )	**Age**	

Hispanic: ☐ **Yes** ☐ **No** ☐ **Unknown**

Race: ☐ **American Indian or Alaska Native** ☐ **Asian** ☐ **Black or African American**

☐ **Native Hawaiian or Other Pacific Islander** ☐ **White** ☐ **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**	_____/_____/_____
☐ **Other**_____	_____/_____/_____

Was patient hospitalized? ☐ **Yes** ☐ **No**

If yes: Hospital _____

Date Admitted _____/_____/_____

Flu Vaccination ☐ **Yes** ☐ **No**

If yes, date received: _____/_____/_____

Patient Symptoms

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

☐ **Headache** ☐ **Nasal congestion**

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

☐ **Body Aches** ☐ **Diarrhea**

☐ **Vomiting** ☐ **Other** _____

Patient Name: _____ DOB: _____

Nasal Vaccination ☐ **Yes** ☐ **No**

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

Date taken: _____/_____/_____

Highest fever during healthcare visit _____° F

Travel outside USA? ☐ **Yes** ☐ **No**

If yes, list country: _____

Date of Travel _____/_____/_____

Does the patient have any of the following?

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_____			

☐ **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: Facility_____

Pregnant?

☐ **Yes** ☐ **No** ☐ **Unknown** ☐ **Not Applicable**

If yes, how many weeks _____

Estimated due date: _____/_____/_____

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 (outpatient)**

☐ **Emergency Department/ER visit**

☐ **In-patient admission (hospitalized patient)**

☐ **Intensive Care Unit (ICU)**

☐ **Other _____**