Tennessee Department of Health

Novel Influenza H1N1 PCR

Instructions: All submissions must complete sections A & B. For all suspect cases, include as much information as possible in sections C-E. Once completed, please submit with specimen to the Tennessee Department of Health, Division of Laboratory Services, 630 Hart Lane, Nashville TN 37216.

A. DEMOGRAPHICS

Last Name: ______________________ **First:** ______________________ **Middle:** ____________________

DOB: ____/____/________ **Reported Age:** ________ ☐ Days ☐ Months ☐ Years **Sex:** ☐ Male ☐ Female

Street Address: ____

City: ______________________ **County:** ____________________ **State:** ______________ **Zip:** ________

Home Phone: ______________________ **Work:** ______________________ **Cell:** ______________________

Ethnicity: ☐ Hispanic ☐ Not Hispanic

Race: ☐ American Indian / Alaskan ☐ Asian ☐ Black / African American ☐ Hawaiian / Pacific Islander ☐ White ☐ Other (_____________)

B. LAB REPORT

Submitting Facility: ______________________________ **Provider:** ______________________________

Street Address: ____

City: ______________________ **County:** ____________________ **State:** ______________ **Zip:** ________

Phone Number: ____________________ **Fax Number:** ____________________ **E-mail:** ______________________

SPECIMEN 1	SPECIMEN 2
Date Specimen Collected: ____/____/_______	**Date Specimen Collected:** ____/____/_______
Specimen Source: ______________________	**Specimen Source:** ______________________
State Lab Accession #: (TDH use only) ______________	**State Lab Accession #:** (TDH use only) ______________

☐ **Check here if specimen is from a state-designated Sentinel Provider (ILINet).**

C. MEDICAL HISTORY

Date of Symptom Onset: ____/____/_______ **Has the patient's symptoms resolved?** ☐ Yes ☐ No ☐ Unknown

Signs and Symptoms: (check all that apply)

☐ Cough ☐ Sore Throat ☐ Fever >37.8°C (100°F) ☐ Feverish, but temp not taken ☐ Diarrhea ☐ Vomiting
☐ Other ____

Was the patient hospitalized for this illness?: ☐ Yes ☐ No ☐ Unknown

***If yes*, was the patient admitted to intensive care unit?** ☐ Yes ☐ No ☐ Unknown

Did the patient die from this illness?: ☐ Yes ☐ No ☐ Unknown ***If yes*, date of death:** ____/____/_______

Is the patient pregnant?: ☐ Yes ☐ No ☐ Unknown

D. EPIDEMIOLOGIC INFORMATION

Is the patient a healthcare worker? ☐ Yes ☐ No ☐ Unknown

***If yes*, what type of facility:** (check all that apply) ☐ Acute care hospital ☐ Long-term care facility ☐ Inpatient mental health facility ☐ Outpatient facility ☐ Other ______________________________

Name of Facility: ______________________________ **Phone Number:** ______________________

During illness, was patient in any of the following: (check all that apply) ☐ Childcare/daycare facility ☐ Correctional facility ☐ Hospital ☐ Long-term care facility ☐ School (Name: ______________________)

E. RELATED CASES

Number of household members (including case-patient): ______________________

Did the patient have close contact (within 6 feet) with a person (e.g., caring for, speaking with or touching) who is a confirmed H1N1 (swine flu) influenza case? ☐ Yes ☐ No ☐ Unknown

ADDITIONAL COMMENTS

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