

Screening Form for Respiratory Viral Testing

(including H1N1)
 (Effective as of 8/1/09)



VCMR ID: _____

Testing for respiratory viruses will only be done if the patient has (check all that apply):

Influenza-like illness (ILI) defined as fever $\geq 37.8^{\circ}\text{C}$ (100°F) and a cough and/or sore throat **AND:**

Admitted to the Intensive Care Unit (ICU), OR

Died Specify date of death: _____

All testing requires pre-approval by ACDC. Call 213-240-7941 and ask for the "doctor on call" for consultation before submitting a specimen to the Public Health Laboratory (PHL) or if a case is suspected novel H1N1, and does not meet the above case definition, but you are requesting testing. After obtaining approval from ACDC, fax this fully completed screening form to ACDC at 213-482-4856 and submit the specimen with specimen submittal form to the appropriate address on the PHL form (available at <http://www.publichealth.lacounty.gov/acd/Diseases/Swine.htm>).

Patient Name-Last	First	Middle Initial	Date of Birth	Age	Sex
Address- Number, Street, Apt #		City	State	ZIP Code	
Hospital Name		Medical Record Number		Date Admitted	

DIAGNOSTIC TESTS

Previous Influenza/Microbiology Testing:

Type of Test (Check all that apply.)	Collection Date	Influenza Result
<input type="checkbox"/> PCR		<input type="checkbox"/> Influenza A non-typable <input type="checkbox"/> Influenza A typable <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative
<input type="checkbox"/> Viral Culture		<input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative
<input type="checkbox"/> Rapid Influenza Test (EIA)		<input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> Influenza A/B <input type="checkbox"/> Negative
<input type="checkbox"/> IFA/DFA		<input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative
<input type="checkbox"/> Other: Specify. _____		

CONTACT INFORMATION

Physician/Infection Preventionist Name	Facility Name	
Physician/ Infection Preventionist Pager/Phone number ()	E-mail Address	Date of Report

Fax this form to: Los Angeles County Department of Public Health
 Acute Communicable Disease Control
Fax 213-482-4856