



Submit Sample(s) to:  
 MN Public Health Laboratory  
 Infectious Disease Lab  
 601 Robert St. N  
 St. Paul, MN 55155

Phone (651) 201-5200  
 Fax (877) 694-4502  
 Specimen Receiving (651) 201-4953  
 CLIA# 24D0651409

Condition: *MDH Lab Use Only*  
 Ambient  
 Refrigerated  
 Frozen  
 Barcode Label

# Influenza Surveillance Submission Form

\*Required Fields

**Submitter**

\*Submitting Facility:  
 \*Address:  
 City: State: Zip:  
 Name of Person Filling Out Form:  
 Phone # for questions/alert values:  
 Ordering Provider:  
 \* Select One:  
 Influenza Surveillance Hospitalized - Project 1492  
 Influenza Surveillance Non-hospitalized - Project 493

**Patient Information**

\*Last Name:  
 \*First Name: MI:  
 Patient Phone Number:  
 Address:  
 City: State: Zip:  
 County:  
 Patient MRN #:  
 \*DOB (mm/dd/yyyy):  
 Sex: Race:  
 Male American Indian/Alaska Native  
 Female Asian  
 Other or Unknown Black  
 Ethnicity: Native Hawaiian/Pacific Islander  
 Hispanic/Latino White  
 Non-Hispanic/Latino Other not listed  
 Not Provided Unknown/Not Provided

**Specimen**

Sample ID:  
 \*Date of Collection (mm/dd/yyyy):  
 Time of Collection (##:##): AM PM  
 \*Transport Media: \*Storage Condition Prior to Transport:  
 VTM/UTM Refrigerated  
 Saline Frozen  
 \*Source: Nasal Swab  
 Nasopharyngeal Swab (NP Swab)  
 Oropharyngeal Swab (OP Swab, Throat Swab)  
 Other, specify:

**Collection Facility Information**

Collection Facility Name:  
 Collection Facility is the same as Submitting Facility.  
 Skip to section - Facility Type  
 Address:  
 City: State: Zip:

**Patient Contact/Tracing Information**

\*Is the patient a resident of a congregate care facility?  
 Yes No Unknown  
 \*Is the patient a healthcare worker with direct patient contact?  
 Yes No Unknown  
 \*Does patient have symptoms? If yes, check all that apply:  
 sore throat shortness of breath  
 nasal congestion difficulty breathing  
 runny nose chills  
 cough fatigue  
 new loss of taste muscle or body aches  
 new loss of smell nausea  
 headache vomiting  
 fever over 100.4 diarrhea  
 feeling feverish Onset Date:  
 Hospital Admission Date if applicable:  
 Employer:  
 Occupation:  
 School (K-12, college /university) or Childcare Attendance:

**Test Information and Comments**

Has patient been vaccinated for influenza? Yes No  
 Unknown Vaccination Date:  
 \*Previous Influenza result?  
 A positive B positive Subtype:  
 A negative B negative  
 \*Test type?  
 Rapid PCR Culture FA  
 Submitting Laboratory, Specify Any Other Information:

Test and Epidemiology Information