

Screening form: MDH PCR Testing for Influenza (Novel H1N1 and Seasonal Influenza)

- All results are provided to the submitting laboratory. Turn-around time is usually 1-2 working days.
- Updated information on novel H1N1 influenza antiviral treatment and chemoprophylaxis is at: <http://www.health.state.mn.us/divs/idepc/diseases/flu/h1n1/hcp/antiviral.html>
- For any atypical situations (i.e. illness clusters), please call 651-201-5414 for consultation.
- Influenza-Like Illness (ILI): Documented fever >37.8°C (>100°F) AND cough and/or sore throat in the absence of another cause

MDH will only test specimens from patients who meet either criterion below:

1. Is the patient hospitalized with ILI or do the patient's ILI symptoms indicate need for hospitalization?
 Y N
If Yes: Hospital: _____ Date of admission: ____/____/____
ICU? Y N Death? Y N
2. Did the patient have direct contact with pigs 14 days before illness onset or have contact with pigs after onset of illness? Y N Unknown

If either of the above criteria is met, then:

1. Complete this form.
2. Complete MDH Request for Testing and Submission of Isolates Form (available at: <http://www.health.state.mn.us/divs/idepc/diseases/flu/h1n1/hcp/testing.html>).
3. Collect specimen.
4. Send both forms with the specimen.

Clinical Information:

1. Specimen collection date: ____/____/____ (Turn-around time is usually 1-2 working days; all results are provided to the submitting laboratory.)
2. In the 14 days before specimen collection, did the patient receive seasonal influenza vaccine as a nasal spray (live attenuated influenza vaccine or LAIV)?
 Y N Unknown If Yes, date: ____/____/____ Date unknown
3. In the 14 days before specimen collection, did the patient receive novel H1N1 influenza vaccine as a nasal spray (live attenuated influenza vaccine or LAIV)?
 Y N Unknown If Yes, date: ____/____/____ Date unknown
4. Is this patient pregnant? Y N Unknown

Patient Demographics: *PLEASE ANSWER ALL QUESTIONS*

Last Name: _____ First Name: _____
Date of Birth: ____/____/____ Age: _____ Sex: M ___ F ___
Street: _____
City: _____ State: _____ Zip: _____
Phone: _____ (cell/home/work) _____ (cell/home/work)
If patient is a minor, name of parent or guardian: _____
Language used at home: English Y N If No, specify language: _____
Is patient a healthcare worker? Y N If Yes, specify where employed: _____

Submitter Information:

Name (person completing form): _____ Phone: _____ FAX 612-863-3186
Provider name (currently responsible for care): _____
Pager/cell: _____
Hospital or Clinic name: _____ City: _____

MDH Use Only:

Cluster: _____

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Minnesota Department of Health - Infectious Disease Epidemiology, Prevention and Control Division
651-201-5414 - TDD/TTY 651-201-5797 - www.health.state.mn.us