

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), for surveillance only.

**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:* \_\_\_/\_\_\_/\_\_\_\_\_

**D. EPIDEMIOLOGIC INFORMATION**

Was the patient in an affected area in the 10 days prior to onset of illness?  Yes  No  Unknown

<input type="checkbox"/> Domestic	City: _____	State: _____	
<input type="checkbox"/> International	City: _____	Country: _____	
Date of Arrival: ___/___/_____	Date of Departure: ___/___/_____		<input type="checkbox"/> Resident
<input type="checkbox"/> Domestic	City: _____	State: _____	
<input type="checkbox"/> International	City: _____	Country: _____	
Date of Arrival: ___/___/_____	Date of Departure: ___/___/_____		<input type="checkbox"/> Resident

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

**E. RELATED CASES**

Number of household members (including case-patient): \_\_\_\_\_

Did the patient have close contact (within 2 meters [6 feet]) with a person (e.g., caring for, speaking with or touching) who is a confirmed swine influenza case?  Yes  No  Unknown