City of Milwaukee Public Health Laboratory

Note: Use for fee-exempt criteria for City of Milwaukee Public Health Laboratory

FEE-EXEMPT 2009 H1N1 INFLUENZA SURVEILLANCE

Use this form to submit specimens that meet criteria for fee-exempt test requests only. **[rev. 9/2009]**

Patient Information		**Submitter Information**
Name (Last, First):		(Your Institution's Agency Number If Known)
Address:		(Your Institution's Name)
City: State: Zip:		(Your Institution's Address)
Date of Birth:	Gender: ☐ **M** ☐ **F**	(City, State, Zip Code)
Occupation: student / day care attendee / heath care worker Other (specify):		(Telephone Number)
Patient Telephone Number:		Health Care Provider Full Name:
Your Patient ID Number (optional):		*MHDL* *Use Only*:
Your Specimen ID Number (optional):		**Name of group or name/address of institution if part of a cluster:**

REQUIRED

REASON FOR TESTING: The patient must have acute febrile respiratory illness AND must meet one of the following criteria to qualify for fee-exempt testing.

- ☐ **Child 2 years of age or less**
- ☐ **Pregnant**
- ☐ **Healthcare Worker**
- ☐ **Death**
- ☐ **Hospitalized (Provide Name & City of Hospital):**
- ☐ **Resident or Staff of Residential or Correctional Facility**
  (Testing additional patients is not necessary once the presence of influenza has been established within a facility.)
- ☐ **Public Health Dept Approval (Provide Name/Agency):**

REQUIRED

Date Collected:	**Specimen Type:** ☐Combined Throat/Nasopharynx Swab (in VTM) ☐Nasopharynx Swab (in VTM) ☐Throat Swab (in VTM) ☐Other

Date of Onset:

General Signs &Symptoms	**Respiratory Signs &Symptoms**	**Digestive Signs &Symptoms**
☐ Anorexia	☐ Conjunctivitis	☐ Diarrhea
☐Arthralgia	☐ Ear Pain	☐ Nausea / Vomiting
☐ Fever *(max. temp*:	☐ Nasal Congestion	**CNS**
☐ Headache	☐ Nasal Discharge	☐ Encephalopathy
☐Lymphadenopathy	☐Pharyngitis	☐Delirium
☐Malaise	☐ Hoarseness	☐Meningismus
☐Myalgia	☐ Cough *(circle/check one)* ☐productive ☐nonproductive ☐barking	
☐ Photophobia	☐ Crackles	
☐ Rash	☐Dyspnea	
☐ Mouth Lesions	☐ Wheeze	
	☐ Pneumonia	

Vaccination History (Influenza): Was patient vaccinated? ☐Unknown ☐ No ☐ Yes (Date Vaccinated:
Type of Vaccine: ☐Seasonal-Inactivated("Flu Shot") ☐Seasonal-Live attenuated("Nasal Spray")
☐2009 (Novel) H1N1-Inactivated ("Flu Shot") ☐2009 (Novel) H1N1-Live attenuated ("Nasal Spray")

Travel History Within 2 Weeks of Onset (Places & Dates):

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Form adapted with permission from the Wisconsin State Laboratory of Hygiene.