

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



**FEE-EXEMPT SWINE INFLUENZA SURVEILLANCE**

*This form is to be used for fee-exempt test requests only; fee-for-service test requests should be written on a routine WSLH form (request at 608-265-2966), to include patient insurance information. [rev. 6/3/09]*

<b>Patient Information</b>		<b>Submitter Information</b>
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 / health care worker Other (specify):		(Telephone Number)
Patient Telephone Number:		Health Care Provider Full Name:
Your Patient ID Number (optional):		WSLH VI ENHANCED-SWINE / Bill To: Account # Use Only:
Your Specimen ID Number (optional):		<b>Name of group or name/address of institution if part of a cluster:</b>

<b>REQUIRED</b>	<b>REASON FOR TESTING:</b> The patient must have acute febrile respiratory illness AND must meet one of the following criteria to qualify for fee-exempt testing.		<b>REQUIRED</b>
	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Child 2 years of age or less	
	<input type="checkbox"/> Healthcare Worker	<input type="checkbox"/> Resident or Staff of Residential or Correctional Facility	
	<input type="checkbox"/> Hospitalized (Name & City of Hospital): _____		
	<input type="checkbox"/> Public Health Dept Approval by (Name/Agency): _____		
	<input type="checkbox"/> Positive Influenza A test result (Specify Test): _____		

<b>Date Collected:</b>	<b>Specimen Type:</b> <input type="checkbox"/> Combined Throat/Nasopharynx Swab (in VTM) <input type="checkbox"/> Nasopharynx Swab (in VTM) <input type="checkbox"/> Throat Swab (in VTM) <input type="checkbox"/> Other _____
------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

**Date of Onset:** \_\_\_\_\_

General Signs & Symptoms	Respiratory Signs & Symptoms	Digestive Signs & Symptoms
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Conjunctivitis	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Arthralgia	<input type="checkbox"/> Ear Pain	<input type="checkbox"/> Nausea / Vomiting
<input type="checkbox"/> Fever (max. temp: _____ )	<input type="checkbox"/> Nasal Congestion	<b>CNS</b>
<input type="checkbox"/> Headache	<input type="checkbox"/> Nasal Discharge	<input type="checkbox"/> Encephalopathy
<input type="checkbox"/> Lymphadenopathy	<input type="checkbox"/> Pharyngitis	<input type="checkbox"/> Delirium
<input type="checkbox"/> Malaise	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Meningismus
<input type="checkbox"/> Myalgia	<input type="checkbox"/> Cough (circle one) <u>productive / nonproductive / barking</u>	
<input type="checkbox"/> Photophobia	<input type="checkbox"/> Crackles	
<input type="checkbox"/> Rash	<input type="checkbox"/> Dyspnea	
<input type="checkbox"/> Mouth Lesions	<input type="checkbox"/> Wheeze	
	<input type="checkbox"/> Pneumonia	

**Vaccination History (Influenza):** Was patient vaccinated?  No  Unknown  
 Yes (Date Vaccinated: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ ) Type of Vaccine:  Inactivated ("Flu Shot")  Live attenuated ("Nasal Spray")

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

**WISCONSIN STATE LABORATORY OF HYGIENE USE ONLY**

**WSLH Test Code: To be determined on receipt**