Suspect Respiratory Virus Patient Form

Form Approved
OMB No. 0920-0004

Complete for all patients for whom specimens are submitted to CDC for virus testing. As soon as possible, please 1) notify and send the completed form to your local/state health department, and 2) include a hard copy of the form along with the 50.34 form for specimen shipment.

Today's Date: ______**Name of person filling in form:** ______ **Phone:** ______ **Email:** ______

Hospital / Health Care Facility Name: ______ **STATE:** ______ **COUNTY:** ______

<MANDATORY> Local Specimen ID (as submitted on 50.34 form for specimen shipment): ______
If multiple specimens are submitted per patient, please include additional specimen IDs in table below

Patient Sex: ☐ M ☐ F **Age:** ______ ☐ Days ☐ Months ☐ Years **Patient's State of Residence** ______

Race: (More than one box can be checked) ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ American Indian or Alaska Native ☐ White **Ethnicity**: ☐ Hispanic ☐ Non-Hispanic
Was patient part of an outbreak? ☐ Y ☐ N If yes, indicate setting: ☐ Hospital ☐ School ☐ Daycare ☐ LTCF ☐ Unknown ☐ Other ______
Date of symptom onset: ______**Medical diagnosis (**if any, e.g., pneumonia, asthma exacerbation**):** ______

Symptoms (*mark all that apply*): ☐ Fever reported (≥100.4° F / 38° C (If yes, highest recorded temperature ______ °F / °C))
☐ Chills ☐ Cough ☐ Wheezing ☐ Sore throat ☐ Runny nose ☐ Stuffy nose/congestion
☐ Shortness of breath / difficulty breathing ☐ Tachypnea ☐ Retractions ☐ Cyanosis ☐ Vomiting
☐ Diarrhea ☐ Rash ☐ Lethargy ☐ Seizure ☐ Conjunctivitis ☐ Other (describe): ______

Does the patient have any comorbid conditions or concurrent risk factors? (*mark all that apply*): ☐ None ☐ Unknown
☐ Asthma ☐ Reactive airway disease / COPD ☐ Bronchopulmonary dysplasia ☐ Cardiac disease ☐ Immunocompromised
☐ Prematurity, if yes gestational age ______ ☐ Wheezing ☐ Pregnancy ☐ Smoking ☐ Other (describe): ______

Diagnostic Imaging (Chest radiograph / CT / Other) ☐ Yes ☐ No ☐ Not Done ☐ Unknown
If yes, please describe any abnormal findings: ______

	Yes	No	Unknown
Is/Was the patient: Hypoxic (sat <93%) on room air?	☐	☐	☐
Treated with supplemental oxygen?	☐	☐	☐
Treated with bronchodilators? (if yes, name: ______________________________________)	☐	☐	☐
Treated with steroids? (if yes, name: ____)	☐	☐	☐
Treated with antibiotics? (if yes, name: ____)	☐	☐	☐
Hospitalized? If Yes, *admission date*: ______; *discharge date, if applicable*: ______	☐	☐	☐
If Yes, was the patient admitted to the Intensive Care Unit (ICU)?	☐	☐	☐
If Yes was the patient placed on non-invasive ventilation (BiPAP/CPAP)	☐	☐	☐
If Yes, was the patient intubated?	☐	☐	☐
If Yes, was the patient placed on ECMO?	☐	☐	☐
Did the patient die? If Yes, *date of death*: ______	☐	☐	☐

General Pathogen Laboratory Testing (*mark all that apply*)

Pathogen	Pos	Neg	Pending	Not Done	Pathogen	Pos	Neg	Pending	Not Done
Influenza A PCR	☐	☐	☐	☐	*Chlamydophila pneumoniae*	☐	☐	☐	☐
Influenza B PCR	☐	☐	☐	☐	*Mycoplasma pneumoniae*	☐	☐	☐	☐
Influenza Rapid Test	☐	☐	☐	☐	*Legionella pneumophila*	☐	☐	☐	☐
RSV	☐	☐	☐	☐	*Streptococcus pneumoniae*	☐	☐	☐	☐
Human metapneumovirus	☐	☐	☐	☐	Blood culture	☐	☐	☐	☐
Parainfluenzavirus	☐	☐	☐	☐	If positive,specify pathogen: ______				
Adenovirus	☐	☐	☐	☐	CSF culture	☐	☐	☐	☐
Rhinovirus and/or Enterovirus	☐	☐	☐	☐	If positive, specify pathogen: ______				
Coronavirus (not MERS-CoV)	☐	☐	☐	☐	Sputum culture	☐	☐	☐	☐
Other: ______	☐	☐	☐	☐	If positive, specify pathogen: ______				
Other: ______	☐	☐	☐	☐					

Submitted Specimen Type(s)	Date Collected	Specimen ID	Submitted Specimen Type(s)	Date Collected	Specimen ID
☐ NP ☐ OP ☐ NP/OP (check one)	______	______	Bronchoalvelolar lavage (BAL)	______	______
Nasal wash / aspirate	______	______	Tracheal Aspirate	______	______
Sputum	______	______	Stool/Rectal swab	______	______
Other: ______	______	______	Other: ______	______	______

To be completed by CDC: ***Patient ID: _____*** ***CSID: _____*** ***CSID: _____*** ***CSID: _____*** ***CSID: _____*** ***CSID: _____***

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-24, Atlanta, Georgia 30333; ATTN: PRA (0920-0004).

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