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: _____				
SARS-CoV-2 (SCV2)	☐	☐	☐	☐	Sputum culture	☐	☐	☐	☐
Coronavirus (not MERS/SCV2)	☐	☐	☐	☐	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:*** _____