

# 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 ( $\geq 100.4^{\circ}\text{F}$  /  $38^{\circ}\text{C}$  (If yes, highest recorded temperature \_\_\_\_\_  $^{\circ}\text{F}$  /  $^{\circ}\text{C}$ ))  
 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Treated with supplemental oxygen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Treated with bronchodilators? (if yes, name: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Treated with steroids? (if yes, name: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Treated with antibiotics? (if yes, name: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalized? If Yes, admission date: _____; discharge date, if applicable: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, was the patient admitted to the Intensive Care Unit (ICU)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Yes was the patient placed on non-invasive ventilation (BiPAP/CPAP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, was the patient intubated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, was the patient placed on ECMO?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the patient die? If Yes, date of death: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Pathogen	Pos	Neg	Pending	Not Done	Pathogen	Pos	Neg	Pending	Not Done
Influenza A PCR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Chlamydomphila pneumoniae</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza B PCR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Mycoplasma pneumoniae</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza Rapid Test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Legionella pneumophila</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RSV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Streptococcus pneumoniae</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Human metapneumovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood culture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parainfluenzavirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If positive, specify pathogen: _____				
Adenovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CSF culture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rhinovirus and/or Enterovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If positive, specify pathogen: _____				
SARS-CoV-2 (SCV2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sputum culture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronavirus (not MERS/SCV2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If positive, specify pathogen: _____				
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

Submitted Specimen Type(s)	Date Collected	Specimen ID	Submitted Specimen Type(s)	Date Collected	Specimen ID
<input type="checkbox"/> NP <input type="checkbox"/> OP <input type="checkbox"/> NP/OP (check one)	_____	_____	Bronchoalveolar lavage (BAL)	_____	_____
Nasal wash / aspirate	_____	_____	Tracheal Aspirate	_____	_____
Sputum	_____	_____	Stool/Rectal swab	_____	_____

Other: _____	_____	_____	Other: _____	_____	_____
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***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).*

*Version 1.0 (fillable), March 24, 2017*