

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°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?	☐	☐	☐
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	☐	☐	☐	☐	Chlamydomphila 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)	_____	_____	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).

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