# 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:*** _____