



Submit Sample(s) to:  
 MN Public Health Laboratory  
 Infectious Disease Lab  
 601 Robert St. N  
 St. Paul, MN 55155

Phone (651) 201-5200  
 Fax (651) 201-5070  
 Specimen Receiving (651) 201-4953  
 CLIA# 24D0651409

Condition: *MDH Lab Use Only*  
 Room Temp  
 Frozen  
 Cool Pack  
 Barcode Label

## Influenza/COVID-19 Non-Hospitalized Submission and Test Request Form (Project 493)

\* Required Fields

**Submitter**

\*Submitting Facility:  
(Results sent here)

\*Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Person Filling Out Form: \_\_\_\_\_

Phone # for questions with form/specimen: \_\_\_\_\_

Phone # for critical/alert values: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_

**Patient**

\*Last Name: \_\_\_\_\_

\*First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Patient Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

County: \_\_\_\_\_

Patient MRN #: \_\_\_\_\_

\*DOB (mm/dd/yyyy): \_\_\_\_\_

Sex:	Race:
Male	American Indian/Alaska Native
Female	Asian
Other or Unknown	Black
Ethnicity:	Native Hawaiian/Pacific Islander
Hispanic/Latino	White
Non-Hispanic/Latino	Other not listed
Not Provided	Unknown/Not Provided

**Specimen**

Sample ID: \_\_\_\_\_

\*Date of Collection (mm/dd/yyyy): \_\_\_\_\_

Time of Collection (##:##): \_\_\_\_\_ AM PM

\*Transport Media: \_\_\_\_\_ \*Storage Condition Prior to Transport: \_\_\_\_\_

VTM/UTM	Refrigerated
Saline	Frozen

\*Source: Nasal Swab  
 Nasopharyngeal Swab (NP Swab)  
 Oropharyngeal Swab (OP Swab, Throat Swab)  
 Other, specify: \_\_\_\_\_

### Collection Facility Information

Collection Facility Name: \_\_\_\_\_

Collection Facility is the same as Submitting Facility.  
 Skip to section - Facility Type

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Patient Contact/Tracing Information

\*Is the patient a resident of a congregate care facility?  
 Yes No Unknown

\*Is the patient a healthcare worker with direct patient contact?  
 Yes No Unknown

\*Does patient have symptoms? If yes, check all that apply:

sore throat	shortness of breath
nasal congestion	difficulty breathing
runny nose	chills
cough	fatigue
new loss of taste	muscle or body aches
new loss of smell	nausea
headache	vomiting
fever over 104	diarrhea
feeling feverish	Onset Date: _____

\*Hospitalization:  
 Patient is Not Hospitalized Patient is Hospitalized Patient is in ICU

Hospital Admission Date if applicable: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

School (K-12, college /university) or Childcare Attendance: \_\_\_\_\_

### Test Information and Comments

Has patient been vaccinated for influenza? Yes No  
 Unknown Vaccination Date: \_\_\_\_\_

\*Previous Influenza result?  
 A positive B positive Subtype: \_\_\_\_\_  
 A negative B negative

\*Test type?  
 Rapid PCR Culture FA

Test Requested: Influenza and COVID-19 PCR (various assays)

Submitting Laboratory, Specify Any Other Information: \_\_\_\_\_

Test and Epidemiology Information