DEPARTMENT OF HEALTH

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

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

Influenza/COVID-19 Non-Hospitalized Submission and Test Request Form

* Required Fields

Submitter

*Submitting Facility: (Results sent here)
*Address:
City: State: Zip:
Name of Person Filling Out Form:
Phone # for questions/alert values:
Ordering Provider:
Project Number: 493

Patient

*Last Name:
*First Name: MI:
Patient Phone Number:
Address:
City: State: Zip:
County:
Patient MRN #:
*DOB (mm/dd/yyyy):

Sex:
- ☐ Male
- ☐ Female
- ☐ Other or Unknown

Ethnicity:
- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Latino
- ☐ Not Provided

Race:
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Other not listed
- ☐ Unknown/Not Provided

Specimen

Sample ID:
*Date of Collection (mm/dd/yyyy):
Time of Collection (##:##): ☐ AM ☐ PM

*Transport Media:
- ☐ VTM/UTM
- ☐ Saline

*Storage Condition Prior to Transport:
- ☐ Refrigerated
- ☐ Frozen

*Source:
- ☐ Nasal Swab
- ☐ Nasopharyngeal Swab (NP Swab)
- ☐ Oropharyngeal Swab (OP Swab, Throat Swab)
- Other, specify:

Test and Epidemiology Information

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
- ☐ nasal congestion
- ☐ runny nose
- ☐ cough
- ☐ new loss of taste
- ☐ new loss of smell
- ☐ headache
- ☐ fever over 104
- ☐ feeling feverish
- ☐ shortness of breath
- ☐ difficulty breathing
- ☐ chills
- ☐ fatigue
- ☐ muscle or body aches
- ☐ nausea
- ☐ vomiting
- ☐ diarrhea

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
- ☐ A negative
- ☐ B negative

Subtype:

*Test type?
☐ Rapid ☐ PCR ☐ Culture ☐ FA

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

Submitting Laboratory, Specify Any Other Information: