



Tennessee Department of Health  
Division of Laboratory Services  
Influenza and SARS-CoV-2 Panel  
Submission Requisition

**State Lab Accession Label**  
(TDH Lab use only, submitting facilities may place their own labels in open requisition space or on the back of this form)

**\*Indicates Required Fields**

(Testing will not be performed if required information is missing)

**SPECIMEN COLLECTION INFORMATION**

<b>*Last Name:</b>		<b>*First Name:</b>		MI:
<b>*Date of Birth:</b>		<b>*Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Pregnancy Status (if relevant): <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Race: <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other			Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
Address:				<b>*County of Residence:</b>
City:	State:	Zip Code:		<b>*Date of Collection:</b>
<b>*Specimen Type</b> (please check one): <input type="checkbox"/> Nasopharyngeal (Preferred) <input type="checkbox"/> Nasal				
<i>Specimen Disqualifications: Do not submit dry swabs, swabs in bacterial culturettes, or swabs that have been used for rapid testing. Specimens should be kept 2°C - 8°C and received in the Dept of Health laboratory within 3 days of collection. Unlabeled or mislabeled specimens cannot be tested; two distinct identifiers required on each tube.</i>				

**SUBMITTER INFORMATION**

<b>*Submitting Facility:</b>			Med Rec/Pat ID Number:
Address:			Phone Number:
City:	State:	Zip Code:	Fax Number:
<input type="checkbox"/> Sentinel Provider Network Provider ID Code (e.g. 47XXX) _____		<input type="checkbox"/> EIP Influenza Hospitals (Selected facilities in Davidson and surrounding counties)	
<input type="checkbox"/> Suspected Novel Influenza Examples include suspected H3N2v or H7N9. Specimen must have an answer of "yes" to one of the Novel Influenza epidemiologic questions. Call 615-741-7247 for medical consultation and testing approval if all answers are "no".			

**\*TEST REQUESTED**

Influenza A, Influenza B and SARS-CoV-2 PCR

**MEDICAL HISTORY**

Date of Symptom Onset:	Have the patient's symptoms resolved? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Signs and Symptoms: (check all that apply) <input type="checkbox"/> Cough <input type="checkbox"/> Sore Throat <input type="checkbox"/> Fever > 37.8°C(100°F) <input type="checkbox"/> Febrile but no measured temp <input type="checkbox"/> Diarrhea <input type="checkbox"/> Vomiting	
Was the patient hospitalized for this illness? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown If yes, was the patient admitted to the intensive care unit? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
Did the patient die from this illness? <input type="checkbox"/> No <input type="checkbox"/> Yes Date: _____ <input type="checkbox"/> Unknown	
Did the patient receive seasonal flu vaccine this season? <input type="checkbox"/> No <input type="checkbox"/> Yes Date: _____ <input type="checkbox"/> Unknown	

**NOVEL INFLUENZA EPIDEMIOLOGY (SECTION INFORMATION ONLY REQUIRED FOR SUSPECTED NOVEL INFLUENZA).**


- Patient attended an agricultural site, auction, or fair (e.g., county fair) in the 7 days prior to becoming ill:  
 No  Yes  Unknown  
If yes, name of fair, etc. \_\_\_\_\_  Unknown
- Patient had direct or indirect contact with pigs (at fair or elsewhere) in 7 days before becoming ill:  
 No  Yes  Unknown
- Patient had direct or indirect contact with poultry or birds in the 7 days before becoming ill:  
 No  Yes  Unknown
- During illness, was patient associated with any of the following (check all that apply):  
 Childcare/daycare Facility  Long-term Care Facility  Correctional Facility  Hospital  School  
Please provide name of Facility: \_\_\_\_\_

**ADDITIONAL INFORMATION**

**LABORATORY SUBMISSIONS**

Nashville Central Laboratory, 630 Hart Lane, Nashville, TN 37216  
Kara Levinson, PhD, MPH, D(ABMM), Public Health Laboratory Director

Main Line: 615-262-6300

		<b>Tennessee Department of Health</b> <b>Division of Laboratory Services</b> <b>Influenza and SARS-CoV-2 Panel</b> <b>Submission Requisition</b>		<b>State Lab Accession Label</b> (TDH Lab use only, submitting facilities may place their own labels in open requisition space or on the back of this form)	
*Indicates Required Fields (Testing will not be performed if required information is missing)					
<b>SPECIMEN COLLECTION INFORMATION</b>					
*Last Name:		*First Name:		MI:	
*State of Birth:		*Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Pregnancy Status (if relevant): <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	
Race: <input type="checkbox"/> American <input type="checkbox"/> Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic			
Address:		*County of Residence:			
City:	State:	Zip Code:	*Date of Collection:		
*Specimen Type (please check one): <input type="checkbox"/> Nasopharyngeal (Preferred) <input type="checkbox"/> Nasal <input type="checkbox"/> Oropharyngeal <small>Specimen Disqualifications: Do not submit dry swabs, swabs in bacterial culturettes, or swabs that have been used for rapid testing. Specimens must be kept 2°C-8°C and received in the Dept of Health laboratory within 3 days of collection or freeze at -70°C and received within 7 days of collection. Unlabeled or mislabeled specimens cannot be tested; two distinct identifiers required on each tube.</small>					
<b>SUBMITTER INFORMATION</b> ★					
*Submitting Facility:		Med Rec/Pat ID Number:			
Address:		Phone Number:			
City:	State:	Zip Code:	Fax Number:		
<input type="checkbox"/> Sentinel Provider Network <small>Provider ID Code (e.g., 47XXX)</small>		<input type="checkbox"/> EIP Influenza Hospitals <small>(Selected facilities in Davidson and surrounding counties)</small>		<input type="checkbox"/> Medical Examiner Office <small>For prior approval contact: Virology Dept. @ 615-262-6350</small>	
<input type="checkbox"/> Suspected Novel Influenza Examples include suspected H3N2v or H7N9. Specimens must have an answer of "yes" to one of the Novel Influenza epidemiologic questions. Call 615-741-7247 for medical consultation and testing approval if all answers are "no".					
<b>TEST REQUESTED</b>					
<input type="checkbox"/> Influenza A, Influenza B and SARS-CoV-2 PCR					
<b>MEDICAL HISTORY</b>					
Date of Symptom Onset:		Have the patient's symptoms resolved? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown			
Signs and Symptoms: (check all that apply)					
<input type="checkbox"/> Cough		<input type="checkbox"/> Sore Throat		<input type="checkbox"/> Fever > 37.8°C (100°F)	
<input type="checkbox"/> Febrile but no measured temp		<input type="checkbox"/> Diarrhea		<input type="checkbox"/> Vomiting	
Was the patient hospitalized for this illness?		<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown		If yes, was the patient admitted to the intensive care unit?	
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown					
Did the patient die from this illness?		<input type="checkbox"/> No <input type="checkbox"/> Yes		Date: <input type="checkbox"/> Unknown	
Did the patient receive seasonal flu vaccine this season?		<input type="checkbox"/> No <input type="checkbox"/> Yes		Date: <input type="checkbox"/> Unknown	
<b>NOVEL INFLUENZA EPIDEMIOLOGY (SECTION INFORMATION ONLY REQUIRED FOR SUSPECTED NOVEL INFLUENZA)</b>					
1. Patient attended an agricultural site, auction, or fair (e.g., county fair) in the 7 days prior to becoming ill:					
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown					
If yes, name of fair, etc. _____ <input type="checkbox"/> Unknown					
2. Patient had direct or indirect contact with pigs (at fair or elsewhere) in 7 days before becoming ill:					
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown					
3. Patient had direct or indirect contact with poultry or birds in the 7 days before becoming ill:					
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown					
4. During illness, was patient associated with any of the following (check all that apply):					
<input type="checkbox"/> Childcare/daycare facility <input type="checkbox"/> Long-term Care Facility <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Hospital <input type="checkbox"/> School					
Please provide name of Facility: _____					
<b>ADDITIONAL INFORMATION (e.g., rapid flu or prescreening results, other clinical findings, etc.)</b>					
<b>LABORATORY SUBMISSIONS</b>					
Nashville Central Laboratory: 630 Hart Lane, Nashville, TN 37216 (FedEx, UPS, courier delivery) OR P.O. Box 305130, Nashville, TN 37230 (USPS)					
Kara Levinson, PhD, MPH, D(ABMM), Public Health Laboratory Director Main Line: (615) 262-6300					
PH 4149 (Rev 05/2023)			RDA 5W03		

Every blank or section on the form denoted with an asterisk ( \* ) is a required field and must have complete information entered for the specimen to be processed.

➤ All mandatory asterisks are shown on the form as.....\*

**Submitter Information (★):** Fill in the organization/clinic/institution's name, address, etc. – not clinicians' names.

### Specimen Comments

- Preferred specimen is a nasopharyngeal (NP) swab
- If this specimen cannot be obtained, a nasal swab is acceptable.

### Swab and Media Considerations

- Specimens must be collected using swabs with a synthetic tip (e.g., polyester or Dacron®)
- Acceptable swabs have an aluminum or plastic shaft.
- Swab specimen collection vials are to contain 1-3 ml of viral transport media (VTM) containing protein stabilizer and antibiotics to discourage bacterial and fungal growth and to buffer solution.

### Storage and Shipping Specifics

- Store specimens at 2-8°C and ship overnight on icepacks or store at less than or equal to -70°C and ship overnight on dry ice.
- If transport/testing will be delayed more than 72 hours after collection, freeze specimen at -70°C or colder. Specimens should be shipped to arrive at the laboratory within 3 days of collection.
- Ship specimens to arrive at the laboratory Tuesday - Friday.
- Ship unfrozen specimens on ice packs.
- Ship frozen specimens on dry ice.
- All infectious substance shipments must conform to U.S. Department of Transportation (DOT) Hazardous Materials Regulations (HMR 49 C.F.R Parts 171-180).

### Infection Control

- Health care personnel who collect respiratory specimens from ill persons should follow standard contact and droplet precautions as recommended for patient care.