MISSISSIPPI STATE DEPARTMENT OF HEALTH

Mississippi Public Health Laboratory
570 East Woodrow Wilson Jackson, MS 39216
Phone: 601-576-7582 / Fax: 601-576-7720
CLIA #: 25D1096223

Influenza and SARS-CoV-2 Surveillance Testing Requisition

Please make sure the information on the form is legible and complete.

SUBMITTER INFORMATION ***PATIENT INFORMATION***

PATIENT ID NUMBER			**PATIENT NAME (LAST)**	**FIRST**	**MI**	**SUFFIX**
SUBMITTER **(facility that will receive the final report)**			**COUNTY OF RESIDENCE**	**DATE OF BIRTH**		
STREET ADDRESS			**STREET ADDRESS**			
CITY	**STATE**	**ZIP**	**CITY**	**STATE**	**ZIP**	
PHONE NUMBER			**PHONE NUMBER**			
CONTACT NAME	**CONTACT NUMBER**		**RACE**			
SPECIMEN SUBMITTED **(Please only submit one specimen type per patient)** ☐ Nasopharyngeal swab (NP) ☐ Oropharyngeal swab (OP) ☐ Nasal mid-turbinate (NMT) ☐ Anterior nares (NS) swab ☐ Nasopharyngeal/Oropharyngeal combined swabs (NP/OP)			☐ American Indian/Alaska Native ☐ Asian ☐ Black ☐ Pacific Islander/ Hawaiian ☐ White/ Caucasian ☐ Other			
TEST REQUESTED ☐ Influenza A, Influenza B and SARS Coronavirus 2 Real-Time RT-PCR			**ETHNICITY** ☐ Hispanic or Latino ☐ Non-Hispanic or Latino	**GENDER** ☐ Male ☐ Female		
DATE OF COLLECTION						

REQUIRED EPIDEMIOLOGICAL INFORMATION (Answer ALL the below questions.)

1. Is the patient symptomatic? ☐ No ☐ Yes ☐ Unknown
   If yes, what was the Date of Symptom Onset ___/_____/____ (MM/DD/YY)
   If yes, mark all symptoms:
   ☐ Fever ≥ 100.0ºF ☐ Sore Throat ☐ Cough ☐ Shortness of Breath ☐ New Loss of Taste or Smell
2. Is the patient hospitalized? ☐ No ☐ Yes
3. Was the patient vaccinated for influenza this season? ☐ No ☐ Yes Date: _____
4. Has the patient travelled recently? ☐ No ☐ Yes If yes, where: _____

Mississippi State Department of Health
Form Instructions
Influenza and SARS-CoV-2 Surveillance Testing Requisition

FORM NUMBER F-930

REVISION DATE June 12, 2020

RETENTION PERIOD The MSDH Laboratory will retain the original form in accordance with Clinical Laboratory Improvement Amendments (CLIA) regulations

PURPOSE

To collect submitter information, patient demographics and specimen information for specimens submitted for Influenza and SARS-CoV-2 testing from approved sentinel influenza providers.

INSTRUCTIONS

SUBMITTER INFORMATION – Left hand side of requisition

Record all requested information

PATIENT ID NUMBER: Enter the submitter's patient identification number.
SUBMITTER: Enter the submitting facility's full name.
STREET ADDRESS: Enter the submitting facility's street address
CITY: Enter the submitting facility's city
STATE: Enter the submitting facility's state
ZIP: Enter the submitting facility's zip code
PHONE NUMBER: Enter the submitting facility's phone number
CONTACT NAME: Enter the name of the submitting facility's contact if applicable
CONTACT NUMBER: Enter the phone number of the submitting facility's contact if applicable

PATIENT INFORMATION – Right hand of requisition

PATIENT NAME: Enter the patient's LAST NAME, FIRST NAME, MIDDLE INITIAL, and SUFFIX in sequence. The spelling of the name on the laboratory slip and the specimen container/tube must be identical. **Name listed must be legal name; DO NOT use nicknames**.
COUNTY OF RESIDENCE: Enter the county where the patient currently resides (Hinds, Rankin, etc.).
DATE OF BIRTH: Provide in MM/DD/YYYY format.
STREET ADDRESS: Enter the complete address where the patient currently resides.
CITY: Enter the name of the city in which the patient resides.
STATE: Enter the state in which the patient resides
ZIP: Enter the Zip Code of the patient's address.
PHONE NUMBER: Enter patient's telephone number including area code.

SPECIMEN SUBMITTED

Submit a NP swab and an OP swab for each patient. If patient has a productive cough, submit one Lower Respiratory Specimen in addition to NP and OP swabs. Provide the Date of collection in MM/DD/YY format

TEST REQUESTED

Check the box by the appropriate test requested.

RACE

Check the box associated with the patient's race

ETHNICITY

Check the appropriate box

GENDER

Check the appropriate box (male or female)

REQUIRED EPIDEMIOLOGICAL INFORMATION

Respond Yes or No to all questions. Provide all applicable information requested.

Mississippi State Department of Health
Form Instructions
Influenza and SARS-CoV-2 Surveillance Testing Requisition Continued

OFFICE MECHANICS AND FILING

This form must accompany each patient for whom specimens are submitted to the MSDH Laboratory. A copy should be retained by the submitter as documentation of submission. Test results will be reported via computer generated report and forwarded to the submitter.