

California Department of Public Health – Viral and Rickettsial Disease Laboratory

Novel Influenza a (H1N1)

Specimen Submittal Form

Respiratory Specimens:

- Each specimen should be labeled with: **date of collection, specimen type, and patient name.**
- Specimens should be collected within the first 24-72 hours of onset of symptoms and no later than 5 days after onset.
- At a minimum, collect a nasopharyngeal swab (nasopharyngeal wash or nasopharyngeal aspirate are also acceptable). Oropharyngeal (throat) swabs are acceptable, but may not have as high yield. If oropharyngeal specimens are collected, they should be accompanied by a specimen from the nasopharynx. Place the swabs in a standard container with 2-3 ml of viral transport media (VTM).
- If the patient is hospitalized with pneumonia, specimens from the lower respiratory tract (e.g., tracheal aspirate, bronchoalveolar lavage) should also be obtained.
- Use dacron-tipped swabs only. Cotton or calcium alginate swabs are **not** acceptable for PCR testing.

Sera:

For cases or contacts of cases with confirmed swine influenza, collect as much blood as possible (recommended volumes 3- 10 cc from children and 10-20 cc from adults) in a serum separator tube (red top or tiger top). If possible, spin to separate sera before packaging.

Specimen Storage and Shipment:

The specimens should be kept refrigerated at 4°C and sent on cold packs if they can be received by the laboratory within five days of the date collected. If samples cannot be received by the laboratory within five days, they should be frozen at -70 °C or below and shipped on dry ice. Specimens should be shipped per usual protocol to either your local public health laboratory or to:

*California Department of Public Health - VRDL Specimen Receiving / Swine Influenza
850 Marina Bay Parkway Richmond, CA 94804 (510) 307-8585*

---Please do not send specimens on a Friday or weekends unless special arrangements have been made with the laboratory---

Patient's last name, first name				Patient's mailing address (including Zip code)				Route to:	
Age	DOB:	Sex (circle): M F	Onset Date:	COUNTY: _____				<input type="checkbox"/> PCR <input type="checkbox"/> ISOL <input type="checkbox"/> FA	
Disease suspected <u>or</u> test requested - <u>Check one</u> : <input type="checkbox"/> Influenza <input type="checkbox"/> other respiratory virus									
1 st	Specimen type and/or specimen source			Date Collected		1 st			
2 nd	Specimen type and/or specimen source			Date Collected		2 nd			
Type or print submitter's complete mailing address				Carol Glaser, DVM, MD, Chief Viral and Rickettsial Disease Laboratory 850 Marina Bay Parkway Richmond, CA 94804 Phone (510) 307-8585 Fax (510) 307-8578					

Local Laboratory Results:

Was this specimen tested by a rapid antigen test? Yes No If yes, result: Pos Neg
 Was this specimen typed as Influenza A? Yes No If yes, was subtype identified? Yes No
If this sample could not be sub-typed, please alert VRDL and provide the ETA and Tracking #

Epidemiologic and Clinical Information (Please attach clinic/hospital notes and laboratory data)

CDC Sentinel Provider patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Outbreak setting? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, setting: <input type="checkbox"/> school <input type="checkbox"/> hospital <input type="checkbox"/> LTCF <input type="checkbox"/> Prison Other []: _____ Health Care Worker? <input type="checkbox"/> Yes <input type="checkbox"/> No Is patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Was patient vaccinated for influenza in 08-09 season? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Other relevant information:	<input type="checkbox"/> Fever to _____°F <input type="checkbox"/> Cough <input type="checkbox"/> Sore throat <input type="checkbox"/> Nausea/vomiting/diarrhea <input type="checkbox"/> Altered Mental Status <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Other, please describe: Is patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No Is patient in the ICU? <input type="checkbox"/> Yes <input type="checkbox"/> No Antiviral treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list drug and start date:
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Submitting Physician: _____ Phone# (_____) _____

Submitting Facility: _____ Fax# (_____) _____