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DEPARTMENT OF MICROBIOLOGY
TEST REQUISITION FORM FOR SWINE FLU

Sample receiving date and time : ____________________

Patient's name	____________________	IPD no	____________________
Age/Sex	____________________	Ward/Unit	____________________
Address	____________________		
District	____________________	Telephone no.	____________________
State	____________________	Occupation	____________________
Date of onset of illness	____________________	Date of admission	____________________

Clinical signs & symptoms:

CATEGORY A	CATEGORY B1	CATEGORY C
☐ Mild fever ☐ Cough ☐ Sore throat ☐ Body ache ☐ Headache ☐ Diarrhea ☐ Vomiting	☐ High grade fever and severe sore throat **CATEGORY B2** Category A with high risk conditions : (any of following) ☐ Pregnancy ☐ Lung diseases ☐ Heart disease ☐ Kidney disease ☐ Diabetes ☐ Liver disease ☐ Immunosupression or cortisone ☐ Neurological disorders ☐ Cancer ☐ Blood disorders	Category A or B with any one or more of following: ☐ Breathlessness ☐ Chest pain ☐ Drowsiness ☐ Fall in BP ☐ Blue nails ☐ Hemoptysis ☐ Irritable child ☐ Refusal to feed ☐ Worsening of underlying chronic conditions

Exposure history:

- **Country visit** **Date of visit** ____________ **Name** ____________
- **Close contact with a person (within 7 days) who is confirmed case of swine flu** **Yes** ☐ **No** ☐
- **Travel to community (within 7 days) where one or more confirmed cases of swine flu have been reported** **Yes** ☐ **No** ☐
- **Resides in a community where there are one or more confirmed swine flu cases.** **Yes** ☐ **No** ☐

Management history:

Chest X-Ray findings ____

Treatment taken ☐ **Yes** ☐ **No** **If yes, what & when** ______________________________

Patient on artificial respiration ☐ **Yes** ☐ **No** **If yes, ventilator/bipap/O2 mask** ____________________

Sample collection:

Type: ☐ **Throat swab** ☐ **Nasopharyngeal swab** ☐ **Other**____ **No. of samples collected:**__ **Date:**_______

Referred from:	Name	Contact no.	Date & time	Sign
Doctor in charge				
Resident doctor				

Email ID of hospital for reporting ______________________________________

Hospital stamp & authorized signature

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