



# Influenza Testing

Please write clearly in dark ink

IMPORTANT: please complete all fields below to avoid delays in processing.

## ADDRESS INFORMATION

Care Home  Nursing Home  HMP  Home  Other

Address:

Postcode:

### SENDERS DETAILS Address:

Consultant: Dr Mike Gent - C3471919  
Location Code: LCOVCH  
Health Protection Team  
Public Health England Yorkshire & Humber  
Leeds  
LS1 4PL

Results to be emailed to: [phe.yorkshirehumber@nhs.net](mailto:phe.yorkshirehumber@nhs.net)

Contact e-mail: [phe.yorkshirehumber@nhs.net](mailto:phe.yorkshirehumber@nhs.net)

Contact phone: 0113 3860300

Ilog Number:

## PATIENT/SOURCE INFORMATION

### NHS number

Surname

Forename

Pregnant

### Sex

male

female

Date of birth

Age

## SAMPLE INFORMATION

Sample type  Nasal Swab  Throat Swab  Nasal/Throat Swab

Date of collection

Time

Date sent

Site

All samples submitted should be treated as though the patient is infected with a Hazard Group 3 Pathogen. All samples must be sent in accordance with Cat B transport guidance.

Please tick the box if your clinical sample is postmortem

## REASON FOR TESTING

Care Home staff

Care Home resident

NHS staff

Index

HMP resident

HMP staff

Other (please specify)

## CLINICAL DETAILS/EPIDEMIOLOGICAL INFORMATION

No symptoms

Symptomatic

Onset date of symptoms

Details of symptoms, eg Cough, Fever, Shortness of breath.  
(please specify)

Underlying Conditions including immunosuppression (please specify)