

DoD Global Influenza Surveillance Program

Swine Influenza Surveillance Questionnaire

Installation: _____ Date of Clinic Visit: _____
DD-MMM-YYYY

PRIVACY ACT STATEMENT: The social security number is required to facilitate documentation of health care received and patient follow-up. The primary use of this information is to aid in preventive health and communicable disease control programs. The requested information is voluntary.

Patient Information PLEASE PRINT LEGIBLY

Patient Name: _____ Date of Birth: _____
Last Name, First Name DD-MMM-YYYY

Patient FMP/Sponsor SSN _____ / _____ - _____ - _____ Gender: Male / Female
FMP Sponsor SSN

Sponsor's (military member) Work Phone (_____) _____ - _____ DSN # _____ - _____

If taken at home, Highest Temp Recorded: _____ Date Taken _____ - _____ - _____
DD-MMM-YYYY

Symptoms: Please select NA (Not Applicable) if the presence of symptoms cannot be determined.

Sore Throat: Yes / No / NA	Cough: Yes / No / NA	Vomiting: Yes / No / NA
Chest Pain: Yes / No / NA	Fatigue: Yes / No / NA	Conjunctivitis: Yes / No / NA
Headache: Yes / No / NA	Chills: Yes / No / NA	Ear Ache: Yes / No / NA
Diarrhea: Yes / No / NA	Body Aches: Yes / No / NA	Stiffness: Yes / No / NA
Dyspnea: Yes / No / NA	Runny Nose: Yes / No / NA	Sinus Congestion: Yes / No / NA

Did the patient travel recently (past 14 days)? Yes No Unknown

If YES, Where? _____ When? _____
City, State/Province, Country

Has the patient received the influenza vaccine this season? Yes No Unknown

If YES, list date _____ Estimated Date: _____ & _____
DD-MMM-YYYY Month 1st half or 2nd half of Mo.

Type: ___ Injection (Flu Shot) ___ Nasal Spray (FluMist)

Location: ___ Military facility ___ Civilian facility

Clinical Information PRINT LEGIBLY

Fever ($\geq 100.0^{\circ}\text{F}$ oral or equivalent) Temp = _____ Subjective Temp = _____
AND (check the symptom/s) a. ___ Cough or b. ___ Sore throat (<72 hours duration)

When did symptoms start? Date: _____ - _____ - _____
DD-MMM-YYYY

Hospitalized? Yes / No If YES, how long (hrs)? _____ Hospital Name? _____

Patient put on Quarters? Yes / No If YES, how long (hrs)? _____

Physician (name and number): _____
Name Contact Phone Number

ILI Case Definition

- Fever > 100.0 F (37.8 C)
oral or equivalent
and
- Cough and/ or Sore Throat
and/ or Runny Nose

Question?
Please contact:
nhrc-fri@med.navy.mil
Phone 619-553-9105

Department of Respiratory Diseases Research Naval Health Research Center

140 Sylvester Road • San Diego, CA 92106 • Tel (619) 553-9105
Fax (619) 553-7601 • email: nhrc-fri@med.navy.mil



Diagnostic Specimen Shipping Instructions

1. Package specimen according to appendix1 (Shipping SOP).
2. All shipments must include four basic requirements:
 - watertight primary containers
 - absorbent material
 - watertight secondary containers
 - sturdy outer packaging
3. Upon request, shipping materials are available from NHRC.
4. A lab requisition form and a specimen log must be included in your specimen shipment.
5. When choosing a courier to ship, use the following guidelines:
 - Shipped in CONUS – use FedEx
 - Shipped OCONUS – use World Courier
6. The outside of all packages must have the following information:
 - Label UN1845 - dry ice (indicating the number of kilograms of dry ice in the package)
 - Label UN3373 – Biological Substance Class B (both must be present)
7. All packages should be shipped to the following address:

Naval Health Research Center
McClelland Rd. and Patterson Rd.
Gate 4, Building 315
ATTN: Laboratory
San Diego, CA 92152

For any questions please contact us at:
nhrc-fri@med.navy.mil
Phone (619) 553-9105



5324

Laboratory Specimen Log

(For Office Use Only)

Request ID:

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Instructions for Completing Specimen Log Form QA-4.50

1. Specimen Logs must be accompanied with a laboratory requisition, form 4.40
2. Use one sheet per specimen/ media type.
3. For serum specimens, enter media type as "None".
4. Specimen collector's initials required for serum samples only.

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Specimen Type

- Quality Control/ Blank
- Aspirate
- Body Fluid
- Body Tissue
- Bronchial
- Bronchial Wash
- Cerebral Spinal Fluid
- Homogenate
- Isolate
- ITCF
- Other: _____
- Lyophilized
- Nasal/Throat Combination
- Nasal Swab
- Serum, Acute
- Serum, Convalescent
- Sputum
- Stool
- Throat Swab
- Whole Blood

Media Type

- None
- A549
- RMK
- Plate
- Slant
- SP4 Broth
- TSB Buffer
- TE Buffer
- UTM
- VTM
- Unknown
- Other: _____

Date Collected MM / DD / YYYY	1st Identifier	2nd Identifier	Comments	Specimen collector initials											
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