WSLH WISCONSIN STATE LABORATORY OF HYGIENE

ENHANCED SURVEILLANCE rev.1/2020

Patient Information		**Submitter Information**
Name (Last, First):		(Your Institution's Agency Number If Known) 215
Address:		(Your Institution's Name) ACL LABORATORIES
City: State: Zip:		(Your Institution's Address) 8901 W. LINCOLN AVE. WEST ALLIS, WI 53227
Date of Birth:	Gender: M F	(City, State, Zip Code)
Occupation:		(Telephone Number) .
Your Patient ID Number (optional):		Health Care Provider Full Name:
Your Specimen ID Number (optional):		*WSLH Use Only* Study: VI SURV-ENHANCED / *WSLH Use Only*: Bill To: (WSLH Account # 74200)

Reason for submission:

☐ **2019 Novel Coronavirus Suspect**
☐ **Avian Influenza Suspect**
☐ **MERS-Coronavirus Suspect**
☐ **Swine Contact**
☐ **Outbreak Investigation (name & location)**_____
☐ **Other** _____

Date Collected:

Specimen Type: ☐ Other_____
☐ Combined Throat/Nasopharynx Swab ☐ Nasopharynx Swab (in VTM) ☐ Throat Swab (in VTM)

Date of Onset:

General Symptoms	**Respiratory Symptoms**	**Digestive Symptoms**
☐ Anorexia	☐ Conjunctivitis	☐ Diarrhea
☐ Arthralgia	☐ Ear Pain	☐ Nausea / Vomiting
☐ Fever	☐ Nasal Congestion	**CNS**
☐ Headache	☐ Nasal Discharge	☐ Encephalopathy
☐ Lymphadenopathy	☐ Pharyngitis	☐ Delirium
☐ Malaise	☐ Hoarseness	☐ Meningismus
☐ Myalgia	☐ Cough *(circle one)* productive / nonproductive / barking	
☐ Photophobia	☐ Crackles	
☐ Rash	☐ Dyspnea	
☐ Mouth Lesions	☐ Wheeze	
	☐ Pneumonia	

Vaccination History (Influenza): Was patient vaccinated? ☐ Yes ☐ No ☐ Unknown
If Yes, Date Vaccinated: / /

Travel History (Places and dates):

Was patient hospitalized? ☐ Yes ☐ No ☐ Unknown
If Yes, where: _____

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WSLH Test Code: To Be Determined On Receipt