

Flu (Influenza) Test - RIDT

Patient's name: _____

Date of birth: _____ Date assessed: _____

Age: _____ Gender: _____ Medical record #: _____

Patient's medical history

History of present illness

How long have they been sick? _____

Key flu symptoms:

Fever Cough Body aches Headache

Other symptoms (check all that apply):

<input type="checkbox"/> Runny nose (clear)	<input type="checkbox"/> Chills
<input type="checkbox"/> Runny nose (yellow/green)	<input type="checkbox"/> Sweats
<input type="checkbox"/> Nose congested/stuffy	<input type="checkbox"/> Chest pain
<input type="checkbox"/> Headache (face/eyes)	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Teeth hurt	<input type="checkbox"/> Difficulty breathing
<input type="checkbox"/> Ear pain	<input type="checkbox"/> Stomach problems

Test information

Rapid influenza diagnostic test used (brand/type):

Sample collection time and date:

Remarks:

Rapid influenza diagnostic test results	Assessment
<ul style="list-style-type: none"><input type="checkbox"/> Positive for Influenza A<input type="checkbox"/> Positive for Influenza B<input type="checkbox"/> Negative<input type="checkbox"/> Invalid result (retake test)	<ul style="list-style-type: none"><input type="checkbox"/> Flu likely because of:<ul style="list-style-type: none">Peak seasonPositive flu testFever and \geq key symptomsStrong clinical suspicion<input type="checkbox"/> Flu unlikely; other diagnosis(es):
Attending physician's name:	
Signature:	Date: