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): ☐ Runny nose (clear)   Chills ☐ Runny nose (yellow/green)   Sweats ☐ Nose congested/stuffy   Chest pain ☐ Headache (face/eyes)   Wheezing ☐ Teeth hurt   Difficulty breathing ☐ Ear pain   Stomach problems
Test information
Rapid influenza diagnostic test used (brand/type):
Sample collection time and date:
Remarks:

Rapid influenza diagnostic test results	Assessment
☐ Positive for Influenza A ☐ Positive for Influenza B ☐ Negative ☐ Invalid result (retake test)	☐ Flu likely because of: Peak season Positive flu test Fever and ≥ key symptoms Strong clinical suspicion ☐ Flu unlikely; other diagnosis(es):
Attending physician's name:	
Signature:	Date: