

# RIDT Flu (Influenza) Test

**Patient's full name:**

**Date of birth:**

**Age:**

**Gender:**

**Medical record #:**

**Attending physician's full name:**

**Patient's medical history:**

**History of Present Illness:**

**How long have you been sick?** \_\_\_\_\_ (Indicate if days, weeks, or months)

## Key flu symptoms:

- Fever
- Cough
- Body aches
- Sore throat
- Headache

## Other symptoms

- Runny nose (clear)
- Runny nose (yellow/green)
- Nose congested/stuffy
- Headache (face/eyes)
- Teeth hurt
- Ear pain
- Chills

- Sweats
- Chest pain
- Wheezing
- Difficulty breathing
- Stomach problems

**Physical Examination:**

Temperature: \_\_\_\_\_

Blood pressure: \_\_\_\_\_

Heart rate: \_\_\_\_\_

	Normal	Abnormal
General	<input type="checkbox"/>	<input type="checkbox"/>
Head	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Ears	<input type="checkbox"/>	<input type="checkbox"/>
Nose	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>

**Chest X-ray:**

- Normal
- Abnormal

**White Blood Cell Count:**

- Not indicated
- WBC: \_\_\_\_\_

**Differential:**

Neutrophils: \_\_\_\_\_

Lymphocytes: \_\_\_\_\_

Monocytes: \_\_\_\_\_

Eosinophils: \_\_\_\_\_

**Notes:**

**Rapid Influenza Diagnostic Test Results:**

- Positive**
- Negative**

**Assessment and Plans:**

- Flu likely because
  - Peak season
  - Positive flu test
  - Fever and  $\geq$  key symptoms
  - Strong clinical suspicion
- Flu unlikely; other diagnosis(es):