# NATIONAL INSTITUTE FOR RESEARCH IN TRIBAL HEALTH

**Nagpur Road, P.O. Garha, Jabalpur – 482 003 (M.P.)**

Telephone no: +91 761 2370800. Fax: +91 761 2370935

Web site: www.rmrct.org E mail: virologyrmrct@rediffmail.com , h1n1rmrct@gmail.com


## A. Identification Section

| Lab code | 0 | 1 | 2 | Year | 1 | 4 | Patient ID *(issued by VDL)* | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

**1.Sample Origin** **Date (*DD/MM/YY*) :** ☐☐/☐☐/☐☐

***Medical College/ Referral Hospital……***

## B. Patient Information

**2. Patient name**

| **3. S/o D/o W/o** | **4. Age in completed years :** | **5. Sex :** *Male* ☐ *Female* ☐ |
|---|---|---|
| **6. Contact Number :** | | |

| **7. Patient Address:** | **Village/Town :** | **Taluk/Tehsil :** | **District :** |
|---|---|---|---|
| | **Pin Code :** | | |

| **8. Patient type** | *a. In-patient* ☐ | *b. Out-patient* ☐ | **9. Hospital OP/IP number :** |
|---|---|---|---|
| **10. Name of clinician:** | | | **11. Clinician's Contact number :** |
| **12. Referral Hospital name:** | | | |

## C. Clinical details (Tick all that apply)

**13. Date of onset of illness (*DD/MM/YY*) :** **14. Duration of illness (in days) :**

| Syndromes | *Associated Symptoms* | | | |
|---|---|---|---|---|
| 15. Diarrhoea ☐ | *1. Fever* ☐ | *2. Diarrhoea* ☐ | *3. Dysentery* | |
| | *4. Pain in abdomen* ☐ | *5. Vomiting* ☐ | *6. Other (specify)* | |
| 16. Respiratory ☐ | *1. Fever* ☐ | *2. Sore throat* ☐ | *3. Cough* ☐ | *4. Rhinorrhoea* |
| | *5. Breathlessness* ☐ | *6. Others (Specify)* | | |
| 17. Fever of Unknown Origin ☐ | *1. Fever* ☐ | *2. Any localizing symptoms* | | |
| 18. Rash ☐ | *1. Fever* ☐ | *2. Macular* ☐ | *3. Papule* ☐ | |
| | *4. Maculo-papular* ☐ | *5. Eschar* ☐ | *6. Pustule* ☐ | |
| | *7. Bullae* ☐ | *8. Others (Specify)* ☐ | | |
| 19. Jaundice ☐ | *1. Fever* ☐ | *2. Jaundice* ☐ | *3. Dark urine* ☐ | *4.Hepatomegaly* ☐ |
| | *5. Nausea* ☐ | *6.Vomiting* ☐ | *7. Abdominal pain/discomfort* ☐ | |
| 20. Encephalitis / Meningitis ☐ | *1. Fever* ☐ | *2. Irritability* ☐ | *3. Increased Somnolence* | |
| | *4. New onset of Seizures* ☐ | *5. Neck rigidity* ☐ | *6. Altered sensorium* | |
| | *7. Change in mental status* ☐ | *8. Others (Specify)* | | |
| 21. Hemorrhagic Fever ☐ | *1. Fever* ☐ | *2. Rigors* ☐ | *3. Headache* ☐ | |
| | *4. Chills* ☐ | *5. Malaise* ☐ | *6. Arthralgia* ☐ | |
| | *7. Myalgia* ☐ | *8. Haemorrhagic manifestations* ☐ | | |
| | *9. Retro-orbital pain* ☐ | *10. Others (Specify)* | | |
| 22. Conjunctivitis ☐ | *1. Fever* ☐ | *2. Redness* | *3. Discharge* ☐ | *4. Crusting* |
| 23. Other Syndrome ☐ | specify | | | |

| 24. Provisional diagnosis : | 25. Investigations Requested : |
|---|---|

## D.EPIDEMIOLOGICAL DETAILS

| | | |
|---|---|---|
| **26.Presence of similar case in the house** | *Yes* ☐ | *No* ☐ |
| **27.Presence of similar case/s in the village/locality** | *Yes* ☐ | *No* ☐ |
| **28.History of travel in last 10 days** | *Yes* ☐ | *No* ☐ |
| | **If *Yes*, place visited** | |

**Consent/Assent**

I am explained and have understood that the sample collected for the diagnosis can be used for diagnosis of other viral agents for research purpose and will aid in understanding and mitigating these diseases. I have no objection for this since my identity will be kept confidential. I am willingly participating in the study.

Name: Doctor/Person filling form: Patientôs/ Guardianôs Signature/Thumb impression

Signature: Doctor/Person filling form:

**Go to Section E (Details of sample collection) on page 2**

| **E.DETAILS OF SAMPLE COLLECTION (Tick all that apply)** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| ***Type of samples*** | Blood(B) | Serum(S) | CSF(C) | NP Swab (N) | Throat swab (T) | Rectal swab (R) | Faeces (F) | Urine (U) | Others (specify) (O) |
| ***Tick (√) samples collected*** | | | | | | | | | |
| ***Date of collection*** | | | | | | | | | |

**For Laboratory Use only**

| **G.LABORATORY RESULTS** | | | | | |
|---|---|---|---|---|---|
| **Sl. No.** | **Virus** *JE / Dengue / Chik / Rota /Measles……..* | **Date of Testing** **(DD/MM/YYYY)** | **Sample Type** *Blood / Serum / CSF / NP Swab / Throat swab / Rectal swap / Stool / Urine……..* | **Test done** *IgM / IgG / PCR / RTPCR / IFA / NT / HA / HI / Antigen detection / Virus isolation……..* | **Result** *Positive (+ ve) Negative ( - ve)* |
| ***1.*** | | | | | |
| ***2.*** | | | | | |
| ***3.*** | | | | | |
| ***4.*** | | | | | |
| ***5.*** | | | | | |
| ***6.*** | | | | | |
| ***7.*** | | | | | |
| ***8.*** | | | | | |
| ***9.*** | | | | | |
| ***10.*** | | | | | |

| **Sample sent to higher lab for further investigations** | Yes | No |
|---|---|---|
| | | |

Name of the Technician:
Date:

Name of the lab in-charge: