NATIONAL INSTITUTE FOR RESEARCH IN TRIBAL HEALTH

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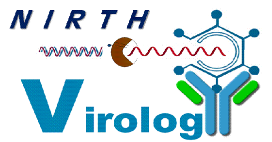

A. Identification Section

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

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

Outbreak / disease cluster from …………………………………

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 7 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 of the person filling form: Patientøs/ Guardianøs Signature/Thumb impression

Signature of 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									

To be filled only for Patients/samples from *Outbreak**

*(samples sent by PHC/CHC/Dist. Health authorities for confirmation of Outbreak/disease cluster)

1. Outbreak Number *(issued by VDL)* ☐ ☐	2. Date of sample collection : ☐☐/☐☐/☐☐☐☐
3. Date of Onset of symptoms: ☐☐/☐☐/☐☐☐☐	4. Total number of patients from whom samples are collected:
	5. Patient Number within the outbreak :
6. Which of the following best describe the clinical presentation? (*Tick most appropriate option*)	
a. *Fever with rash (suspected measles/rubella)* ☐	b. *Fever with rash, arthralgia (suspected dengue)* ☐
c. *Fever with arthralgia (suspected Chikungunya)* ☐	d. *Fever with respiratory symptoms (suspected influenza)* ☐
e. *Fever with jaundice (suspected HAV/HEV)* ☐	f. *Fever with neurological symptoms (suspected JE)* ☐
g. *Fever with hemorrhagic manifestations* ☐	h. *Acute diarrhoeal disease* ☐
i. *Conjunctivitis* ☐	j. *Gastroenteritis (probably food borne)* ☐
k. *Acute flaccid paralysis* ☐	l. *Others (Specify)* ☐
07. Provisional diagnosis :	08. Investigations Requested :

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: