Sri Venkateswara Institute of Medical Sciences, Tirupati- 517 507

DHR-ICMR Virus Research and Diagnostic Laboratory Network

A. Identification Section

Lab code	0	2	9	Year	1	6	Patient ID *(issued by VRDL)*					

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

Outbreak / disease cluster (Referred by Public Health Authorities)…….☐(go to page 2)

Outbreak / disease cluster (investigated by VRDL……………………………☐(go to page 2)

Medical College/ Referral Hospital………………………………………………………☐

Outbreak : Investigation date
Medical college/Ref. Hosp. : Patient Visit date (OP) / Admission date(IP)

B. Patient Information

2.Patient name			
3.S/o D/o W/o		**4.Age in completed years :**	***For Infants*** *months* *days*
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.Others (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 mentalstatus☐	*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

Name of the person filling form :

Signature of person filling form :

Go to Section F (Details of sample collection) in Page 2

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

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

E. Patient Information (to be filled by VRDL)			
1.Patient name		**2.S/o D/o W/o**	
3.Age in completed years :	***For Infants*** *months* ☐☐ *days* ☐☐		**4.Sex** : *Male*☐ *Female*☐
5.Patient Address:	**Village/Town :**	**Sub Centre :**	**PHC/CHC :**
	District :	**Pin Code :**	
Contact details of the official referring the samples from outbreak:	**Name:**		**Ph:**

6. Outbreak Number *(issued by VRDL)*☐☐	7. Date of sample collection : ☐☐/☐☐/☐☐☐☐
8. Date of Onset of symptoms: ☐☐/☐☐/☐☐☐☐	9. Total number of patients from whom samples are collected:
	10. Patient Number within the outbreak :
11. 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)* ☐
12. Provisional diagnosis :	13. Investigations Requested :

F. Details of Sample Collection (Tick all that apply)

Type of samples	Blood-Plasma(P)	Blood-Serum(S)	CSF(C)	NP Swab (N)	Throat swab (T)	Rectal swab (R)	Faeces (F)	Urine (U)	Others (specify) (O)
Tick (√) for the samples collected									
Date of collection									

ONLYFORLABORATORY USE

G. Laboratory Results

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

Sample sent to higher lab for further investigations	Yes	No

Name of the Technician :

Name of the lab in-charge :

Date :