VRDL- ICMR-RMRC, GORAKHPUR

DHR-ICMR Virus Research and Diagnostic Laboratory Network (Ver 3.0)

A. Identification Section

Lab code				Year			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 :	**State :**	**Rural / Urban / NK :**
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 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

Name of the person filling form :

Signature of person filling form :

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

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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 :**	**State :**		**Rural / Urban / NK :**
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									

ONLY FOR LABORATORY 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 :