REGIONAL VIROLOGY LABORATORY, AIIMS, BHOPAL
DHR-ICMR Virus Research and Diagnostic Laboratory Network

A. Sample Source

1.Tick whichever is appropriate:

Outbreak / disease cluster (Referred by Public Health Authorities)..... ☐

Outbreak / disease cluster (investigated by VRDL..... ☐

Medical College/ Referral Hospital..... ☐

Date (*DD/MM/YY*) : ☐☐/☐☐/☐☐

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 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

E. Investigations Requested (Please encircle)

Dengue (NS1 Ag ELISA)	Hepatitis E (IgM ELISA)	Hepatitis B (HBsAg ELISA)	Measles (IgM ELISA)	Varicella Zoster (IgM ELISA)	Zika virus (RT-PCR)	
Dengue (IgM ELISA)	Enterovirus (PCR)	Hepatitis C (Anti-HCV ELISA)	Mumps (IgM ELISA)	Cytomegalo virus (IgM ELISA)	Influenza A H1N1 (RT-PCR)	
Chikungunya (IgM ELISA)	Rota Virus (RotaAg ELISA)	West Nile Virus (IgM ELISA)	Rubella (IgM ELISA)	Epstein-Barr virus (IgM ELISA)		

Name of the person filling form :

Signature of person filling form :

F. Sample identification (To be filled by VRDL)

Lab code				Year			Patient ID *(issued by VRDL)*					