



# REGIONAL VIROLOGY LABORATORY, AIIMS, BHOPAL

## DHR-ICMR Virus Research and Diagnostic Laboratory Network

### 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)

| A. Patient Information (to be filled by VRDL)                                                                                                                                                                                                |  |                |                    |  |                                                                                                                                                                                                                                            |  |      |           |                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------|--------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------|-----------|------------------------------------------------------------------------|
| 1. Patient name                                                                                                                                                                                                                              |  |                |                    |  | 2. S/o D/o W/o                                                                                                                                                                                                                             |  |      |           |                                                                        |
| 3. Age in completed years :                                                                                                                                                                                                                  |  |                | <i>For Infants</i> |  | months                                                                                                                                                                                                                                     |  | days |           | 4. Sex : Male <input type="checkbox"/> Female <input type="checkbox"/> |
| 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) <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                        |  |                |                    |  | 7. Date of sample collection : <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |  |      |           |                                                                        |
| 8. Date of Onset of symptoms:<br><input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |  |                |                    |  | 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) <input type="checkbox"/>                                                                                                                                                                      |  |                |                    |  | b. Fever with rash, arthralgia (suspected dengue) <input type="checkbox"/>                                                                                                                                                                 |  |      |           |                                                                        |
| c. Fever with arthralgia (suspected Chikungunya) <input type="checkbox"/>                                                                                                                                                                    |  |                |                    |  | d. Fever with respiratory symptoms (suspected influenza) <input type="checkbox"/>                                                                                                                                                          |  |      |           |                                                                        |
| e. Fever with jaundice (suspected HAV/HEV) <input type="checkbox"/>                                                                                                                                                                          |  |                |                    |  | f. Fever with neurological symptoms (suspected JE) <input type="checkbox"/>                                                                                                                                                                |  |      |           |                                                                        |
| g. Fever with hemorrhagic manifestations <input type="checkbox"/>                                                                                                                                                                            |  |                |                    |  | h. Acute diarrhoeal disease <input type="checkbox"/>                                                                                                                                                                                       |  |      |           |                                                                        |
| i. Conjunctivitis <input type="checkbox"/>                                                                                                                                                                                                   |  |                |                    |  | j. Gastroenteritis (probably food borne) <input type="checkbox"/>                                                                                                                                                                          |  |      |           |                                                                        |
| k. Acute flaccid paralysis <input type="checkbox"/>                                                                                                                                                                                          |  |                |                    |  | l. Others (Specify) <input type="checkbox"/>                                                                                                                                                                                               |  |      |           |                                                                        |
| 12. Provisional diagnosis : <input type="checkbox"/>                                                                                                                                                                                         |  |                |                    |  | 13. Investigations Requested : <input type="checkbox"/>                                                                                                                                                                                    |  |      |           |                                                                        |

| B. 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

| C. Laboratory Results                                |                                          |                 |                                                                                  |                                                                                         |                                                 |
|------------------------------------------------------|------------------------------------------|-----------------|----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------|
| Sl. No.                                              | Virus                                    | Date of Testing | Sample Type                                                                      | Test done                                                                               | Result                                          |
|                                                      | JE / Dengue / Chik / Rota / Measles..... | (DD/MM/YYYY)    | Plasma / Serum / CSF / NP Swab / Throat swab / Rectal swap / Faeces / Urine..... | IgM / IgG / PCR / RTPCR / IFA / NT / HA / HI / Antigen detection / Virus isolation..... | Positive (+ ve)<br>Negative (- ve)<br>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 :