GLOBAL TASK FORCE ON CHOLERA CONTROL

GTFCC Laboratory Referral Form for Cholera Suspected Case

The referring health worker is to complete this form and send a copy to the laboratory with the specimen (one form per specimen sent).

Please attach a copy of the Admission and Triage Form.

For specific instructions for packaging and transportation please refer to Specimen Packaging and Domestic Transportation for Laboratory Confirmation of *Vibrio cholerae* O1/O139.

Request made by

Name of health facility (or stamp or health facility identifier)

Date of request: DD MM YYYY __ __ / __ __ / __ __ __ __

Name of referring health worker: .....

Address: .....

Phone: ..... E-mail: .....

Request made for

☐ Laboratory identification of Cholera ☐ Antimicrobial Susceptibility Testing ☐ Other, specify .....

Specimen

Specimen ID: ..... Date and time of collection: DD MM YYYY Hour Minute __ __ / __ __ / __ __ __ __ __ __ __ __

Location specimen collected: .....

Type of specimen collected: ☐ Stool ☐ Rectal swab ☐ Other, specify: .....

Blood observed in stool: ☐ Yes ☐ No

Appearance of specimen: ☐ Formed ☐ Soft ☐ Watery ☐ Bloody-mucus

Conditioning of stool sample[1]: ☐ Stool in container (no added reagents) ☐ in Cary Blair ☐ in Alkaline Peptone Water (APW) ☐ on filter paper ☐ other, specify: .....

.....

Date specimen sent to referral laboratory: DD MM YYYY __ __ / __ __ / __ __ __ __

If date of specimen collection and date specimen sent are different, how was the specimen stored (media, temperature)? .....

.....

Was an RDT performed on the same specimen? ☐ No ☐ Yes, specify: ☐ Enriched RDT ☐ Direct RDT

Result: ☐ Reactive O1 ☐ Reactive O139 ☐ Reactive O1 and O139 ☐ Non-reactive ☐ Invalid

Name of RDT kit used: .....

1 To be sent at ambient temperature (ideally 22-25°C). Do not refrigerate or freeze. Keep out of sunlight.

Patient

Last name: ..... **First name:** .....

Patient ID: ..... **Sex:** ☐ Male ☐ Female

Age: __ __Years/__ __Months/__ __ Days or Date of birth DD __ __ / MM __ __ / YYYY __ __ __ __

Date of onset of illness: DD __ __ / MM __ __ / YYYY __ __ __ __

Where did the patient first feel sick? Region/Province ..... District .....Town .....

Patient outcome at time of request: ☐ Hospitalized ☐ Discharged ☐ Deceased ☐ Self-discharged
☐ Referred, specify ..... ☐ Unknown

Antibiotics treatment received prior to collection of sample:* ☐ No ☐ Yes

**Any antibiotics received by the patient prior to sample collection may negatively impact laboratory results.*

Specify which antibiotic: .....

Specify dose of antibiotic: .....Specify duration of treatment (days): .....

Oral Cholera Vaccine (OCV) received: ☐ Unknown ☐ No ☐ Yes When? DD __ __ / MM __ __ / YYYY __ __ __ __

Name of OCV: .....

Relevant travel history .....

Signs & symptoms

☐ Watery stool ..... days
☐ Bloody stool ..... days
☐ Vomiting ..... days
☐ Fever ..... days
☐ Lethargy
☐ Loss of consciousness
☐ Absent or weak pulse
☐ Respiratory distress
☐ Sunken eyes
☐ Unable to drink or drinking poorly
☐ Skin pinch going back very slowly (>2 seconds)

Other symptoms .....

Any known contacts with anyone with similar symptoms?
☐ No ☐ Yes, specify .....

To be completed upon reception of the specimen by the receiving laboratory

Recipient laboratory (name/ address or stamp)

Name of lab personnel performing sample intake: .....

Date and time of specimen received: DD __ __ / MM __ __ / YYYY __ __ __ __ Hour __ __ Minute __ __

Condition of specimen/packaging/documentation: ☐ Adequate ☐ Not adequate

If not adequate, specify (e.g. leaking, missing information, inadequate transportation or conservation temperature): .....

.....

Follow up actions: ☐ obtain a second sample ☐ complete missing information ☐ other, specify: .....