

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 ([Appendix 12 of the Cholera Outbreak Manual](#)).

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 sample¹: 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: Positive Negative Indeterminate

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: ___/___/_____

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	
<input type="checkbox"/> Watery stool days	<input type="checkbox"/> Respiratory distress
<input type="checkbox"/> Bloody stool days	<input type="checkbox"/> Sunken eyes
<input type="checkbox"/> Vomiting days	<input type="checkbox"/> Unable to drink or drinking poorly
<input type="checkbox"/> Fever days	<input type="checkbox"/> Skin pinch going back very slowly (>2 seconds)
<input type="checkbox"/> Lethargy	Other symptoms
<input type="checkbox"/> Loss of consciousness	Any known contacts with anyone with similar symptoms?
<input type="checkbox"/> Absent or weak pulse	<input type="checkbox"/> No <input type="checkbox"/> 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: