



# REGIONAL VIROLOGY LABORATORY, AIIMS BHOPAL

## DHR-ICMR Virus Research and Diagnostic Laboratory Network



### A. Sample Source

1. Tick whichever is appropriate: Outbreak: Investigation date .....  
 Outbreak / disease cluster (Referred by Public Health Authorities)  Patient Visit date (OP) / Admission date(IP): .....  
 Outbreak / disease cluster (investigated by VRDL).....  Date of sample collection (DD/MM/YY): .....  
 Medical College/ Referral Hospital/Self-referred.....  Sample Type: Serum  Blood  CSF  Urine  Nasopharyngeal swab  Stool

### 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  Transgender       6. Contact no. :      7. Locality: Rural  Urban  Sub-urban

8. Local address      House No. /locality      Village/Town :  
 Taluk/Tehsil :      District :      Pin Code :

9. Permanent address      House No. /locality      Village/Town :  
 Taluk/Tehsil :      District :      Pin Code :

10. Patient      a. In-patient  b. Out-patient  c. Self-referred       9. Hospital OP/IP number :

11. Name of clinician:      12. Clinician's Contact number :

13. Referral Hospital name:

### C. Clinical Details (Tick all that apply)

14. Date of onset of illness : ...../...../.....      15. Duration of illness (in days) : .....      16. Condition: Stable  Critical

| Syndromes  | Associated Signs & Symptoms                         |   |   |  |
|--|---|---|---|--|
| 17. <input type="checkbox"/> Diarrhoea                 | 1. <input type="checkbox"/> Fever                   | 2. <input type="checkbox"/> Diarrhoea                   | 3. <input type="checkbox"/> Dysentery                 |  |
|  | 4. <input type="checkbox"/> Pain in abdomen         | 5. <input type="checkbox"/> Vomiting                    | 6. <input type="checkbox"/> Others (specify)          |  |
| 18. <input type="checkbox"/> Respiratory               | 1. <input type="checkbox"/> Fever                   | 2. <input type="checkbox"/> Sore throat                 | 3. <input type="checkbox"/> Cough                     | 4. <input type="checkbox"/> Rhinorrhoea  |
|  | 5. <input type="checkbox"/> Breathlessness          | 6. <input type="checkbox"/> Others (Specify)            |   |  |
| 19. <input type="checkbox"/> Fever of Unknown Origin   | 1. <input type="checkbox"/> Fever                   | 2. <input type="checkbox"/> Any localizing symptoms     | 3. <input type="checkbox"/> Leukopenia                |  |
| 20. <input type="checkbox"/> Rash                      | 1. <input type="checkbox"/> Fever                   | 2. <input type="checkbox"/> Macular                     | 3. <input type="checkbox"/> Papule                    |  |
|  | 4. <input type="checkbox"/> Maculo-papular          | 5. <input type="checkbox"/> Eschar                      | 6. <input type="checkbox"/> Pustule                   |  |
|  | 7. <input type="checkbox"/> Bullae                  | 8. <input type="checkbox"/> Others (Specify)            |   |  |
| 21. <input type="checkbox"/> Jaundice                  | 1. <input type="checkbox"/> Fever                   | 2. <input type="checkbox"/> Jaundice                    | 3. <input type="checkbox"/> Dark urine                | 4. <input type="checkbox"/> Hepatomegaly |
|  | 5. <input type="checkbox"/> Nausea                  | 6. <input type="checkbox"/> Vomiting                    | 7. <input type="checkbox"/> Abdominal pain/discomfort |  |
| 22. <input type="checkbox"/> Encephalitis / Meningitis | 1. <input type="checkbox"/> Fever                   | 2. <input type="checkbox"/> Irritability                | 3. <input type="checkbox"/> Increased Somnolence      |  |
|  | 4. <input type="checkbox"/> New onset of Seizures   | 5. <input type="checkbox"/> Neck rigidity               | 6. <input type="checkbox"/> Altered sensorium         |  |
|  | 7. <input type="checkbox"/> Change in mental status | 8. <input type="checkbox"/> Others (Specify)            |   |  |
| 23. <input type="checkbox"/> Hemorrhagic Fever         | 1. <input type="checkbox"/> Fever                   | 2. <input type="checkbox"/> Rigors                      | 3. <input type="checkbox"/> Headache                  |  |
|  | 4. <input type="checkbox"/> Chills                  | 5. <input type="checkbox"/> Malaise                     | 6. <input type="checkbox"/> Arthralgia                |  |
|  | 7. <input type="checkbox"/> Myalgia                 | 8. <input type="checkbox"/> Haemorrhagic manifestations |   |  |
|  | 9. <input type="checkbox"/> Retro-orbital pain      | 10. <input type="checkbox"/> Leukopenia                 | 11. <input type="checkbox"/> Others (Specify)         |  |
| 24. <input type="checkbox"/> Conjunctivitis            | 1. <input type="checkbox"/> Fever                   | 2. <input type="checkbox"/> Redness                     | 3. <input type="checkbox"/> Discharge                 | 4. <input type="checkbox"/> Crusting     |
| 25. <input type="checkbox"/> Other Syndrome            | Specify   |   |   |  |

26. Provisional diagnosis :      25. Investigations Requested :

### D. Epidemiological Details

27. Presence of similar case in the house      Yes  No       28. Presence of similar case/s in the village/locality      Yes  No       29. History of travel in last 10 days      Yes  No   
 If Yes, place visited :      No

### E. Investigations Requested (Please encircle)

|                                     |                                |                                      |                                |                           |                                      |                                |
|-------------------------------------|--------------------------------|--------------------------------------|--------------------------------|---------------------------|--------------------------------------|--------------------------------|
| Japanese encephalitis (IgM ELISA)   | Dengue (NS1 Ag ELISA)          | Hepatitis A (IgM ELISA)              | Hepatitis B (HBsAg ELISA)      | Measles (IgM ELISA)       | Varicella Zoster (IgM ELISA)         | West Nile Virus (IgM ELISA)    |
| Influenza A H1N1 (Real Time RT-PCR) | Dengue (IgM ELISA)             | Hepatitis E (IgM ELISA)              | Hepatitis C (Anti-HCV ELISA)   | Mumps (IgM ELISA)         | Cytomegalovirus (IgM ELISA)          | Herpes Simplex Virus (PCR)     |
| Human Parvovirus (IgM ELISA)        | Chikungunya (IgM ELISA)        | Rotavirus (RotaAg ELISA)             | Hepatitis D (Anti-HDV ELISA)   | Rubella (IgM ELISA)       | Epstein-Barr virus (IgM ELISA)       | Enterovirus (RT-PCR)           |
| Zika virus (Real Time RT-PCR)       | Influenza B (Real Time RT-PCR) | Respiratory Syncytial Virus (RT-PCR) | Human Metapneumovirus (RT-PCR) | Human Rhinovirus (RT-PCR) | Human parainfluenza viruses (RT-PCR) | Respiratory Adenoviruses (PCR) |

**Respiratory viral panel** (Influenza A & B, Respiratory Syncytial Virus, Human Metapneumovirus, Human Rhinovirus, Human Parainfluenza Virus, Respiratory Adenoviruses)

Name of the person filling form :      Signature of person filling form :

### F. Sample identification (To be filled by VRDL)

VRDL ID      Date and time of sample receiving      Sample received by