**National Virus Reference Laboratory**
**University College Dublin**
**Belfield Dublin 4**

**Tel General Enquiries: 01 716 4401**
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# VHF INVESTIGATION REQUEST FORM

## PATIENT DETAILS

**Forename:**

**DOB:** D D M M Y Y Y Y

**Surname:**

**Sex :** F M

**Address:**

## SPECIMEN DETAILS

**Specimen Type(s):** Serum Plasma

**Other:**

**Specimen Date & Time of collection:** D D M M Y Y Y Y H H M M

## CLINICAL DETAILS

Clinical details aid the selection of an optimal testing strategy. Please include duration of illness and associated travel information

**Date of onset of symptoms:** D D M M Y Y Y Y

**TRAVEL HISTORY (within previous 21 days):**

**Date Returned:**

**Contact History:**

**Clinical Features (tick box if present):**

| | | | |
|---|---|---|---|
| Fever ........................ | ☐ | Haemorrhagic features | ☐ |
| Rash ......................... | ☐ | Sore throat ............. | ☐ |
| Myalgia ................... | ☐ | Arthralgia ................ | ☐ |
| Vomiting ..................... | ☐ | Meningitis ............... | ☐ |
| Diahorrea ................... | ☐ | Respiratory symptoms .. | ☐ |
| Endocarditis ................ | ☐ | Lymphopenia ........... | ☐ |
| Thrombocytopenia ......... | ☐ | Abnormal LFTs .......... | ☐ |
| Leucopenia ................. | ☐ | | |

Other relevant features: ___________________________________

## INVESTIGATION REQUIRED

**NVRL Contacted** ☐

**Investigation required:**

Ebola ☐

Marburg ☐

Lassa ☐

CCHF ☐

## DOCTOR / SURGERY DETAILS/REQUESTING HOSPITAL DETAILS

**Name:**

**Signature:**

**IMC No:**

**Date:** D D M M Y Y Y Y

**Tel:**



This is a controlled document