National Virus Reference Laboratory
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Belfield Dublin 4

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VHF INVESTIGATION REQUEST FORM

PATIENT DETAILS

Forename: | Sex: M/F | DOB:

Surname: | Hospital Number (Mandatory if available)

Address: | Lab Number (Mandatory if available)

SPECIMEN DETAILS

Sample type: Serum | Plasma | Other:

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

Sample Collection Details

Sample taken by | Signature

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:

Surgery Address/Hospital Address/ Stamp

NB: Please not that the sample will not be processed without the address of hospital or surgery