National Virus Reference Laboratory
University College Dublin
Belfield Dublin 4

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VHF INVESTIGATION REQUEST FORM

PATIENT DETAILS

Forename:

Surname:

Address:

DOB: D D M M Y Y Y Y

Sex : F M

Hospital Number

Hospital Lab Number

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