National Virus Reference Laboratory
University College Dublin
Belfield Dublin 4

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VHF INVESTIGATION REQUEST FORM

PATIENT DETAILS

Forename:

Surname:

DOB: D D M M Y Y Y Y

Sex : F M

Hospital Number

Hospital Lab Number

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:

Surgery Address/Hospital Address/ Stamp

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