PIC AFP Laboratory Request Form

(To accompany stool specimen shipment to Laboratory)

Country:	EPID#		
Patient's name:		M	F
Address:_____ Village/Town/City: _____ Commune: District: State/Province:			
	Day	Month	Year
Date of birth of patient:			
If patients birth date is unknown, approximate age is: ____ years and _____ months old			
Date of paralysis onset			
Date of first stool specimen collection:			
Date of second stool specimen collection:			
Date stool specimens sent:			
Date of last dose of OPV (where applicable):			
Preliminary clinical diagnosis:			
Name(s) of person to whom laboratory results should be sent:			
Complete address:_____			
Telephone number: Fax number(s): Email address:			

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(For use by the receiving laboratory)

	Day	Month	Year
Date specimen received at Laboratory:			
Name of person receiving specimen at laboratory:			
Was specimen in good condition:			

Criteria for "good" condition = adequate volume, no leakage, no desiccation, and temperature indicator of presence of ice indicating reverse cold chain was maintained.