PIC AFP Laboratory Request Form

*(To accompany stool specimen shipment to Laboratory)*

|  |  |
| --- | --- |
| Country: | EPID# |
| Patient's name: | M | F |
| Address: Commune:State/Province: | Village/Town/City: District: |   |
| Date of birth of patient: | Day | Month | Year |
|  |  |  |
| 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: Email address: | Fax number(s): |  |

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(For use by the receiving laboratory)

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| --- | --- | --- | --- |
| Date specimen received at Laboratory: | Day | Month | Year |
|  |  |  |
| 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.