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.