Ministry of Health Laboratory Investigation Form for Coronavirus Disease (COVID-19)

Date:[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_]	Unique Lab ID:			Serial number:

Requester's info	NAME	FACILITY	PHONE

1. Where is sample collected? □ Patient home □ Health facility (specify): _____
□ Point of entry (specify): _____ □ Institution (specify): _____ □ Other: _____

2. Who is being tested? □ Case □ Contact □ Point-of-entry □ Quarantine □ Alert □ Health worker □ Other: _____

3. Reason for health worker (HW) testing? □ Routine exposure □ Quarantine □ Other_____ □ **HW's facility:** _____

4. If person is isolated/quarantined, specify day of testing: □ Day 0 □ Day 7 □ Day 13 □ Other: _____

5. Patient traveled out of Uganda in 2 wks before onset (or sample-taking, if no symptoms)? □Yes □No

6. If yes, where: **7. Return date**: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_]

Section 1: Patient information

1. Surname **2. First name** **3. Sex** □ M □ F

4. DOB: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_] ***or***
estimated age: [___][___] years if <1 year, [___][___] months if <1 month, [___][___] days

5. Nationality **6. Phone #**:

7. Address: Village _____ Parish _____Sub-county_____ District_____

8. Next-of-kin: **9. Next-of-kin phone number:**

10. Car vehicle plate number: **11. Vehicle destination:**

Section 2: Clinical Information

12. Is/was patient symptomatic? □ Yes □ No **-->If NO, skip to Question 15**

13. Date of onset of first symptom: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_]

14. Symptoms □ Cough □ Fever □ Sore throat □ Shortness of breath □ Headache
□ Chest pain □ Runny nose □ General weakness □ Chills □ Other, specify: _____

15. Known underlying conditions: □ Pregnancy (trimester: ____) □ Post-partum (< 6 weeks) □ TB □ HIV
□ Neurological disease □ Cardiovascular disease □ Hypertension □ Diabetes □ Renal disease
□ Chronic lung disease □ Liver disease □ Malignancy, specify: _____ □ Other, specify: _____

Section 3: Specimen collection

Specimen type	Date of specimen collection	Unique Lab ID	Lab specimen sent to:
□ NP/OP swab	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_]		
□ Blood	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_]		
□ Other, _____	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_]		

Section 4: Provisional results (Lab copy): Filled in by tester

Tester's name **Tester's phone #** **Tester's facility:**

Test	Results	Date of results return	Patient contact info for return of results (phone, email)
□ RDT antigen	□ positive □ negative	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_]	
□ RDT antibody	□ positive □ negative	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_]	
□ PCR (e.g., GXP)	□ positive □ negative	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_]	

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Section 5: Provisional results (client copy): Filled in by tester

Unique Lab ID:

Patient surname _____ **Patient first name** _____

Specimen was:	Test	Results	Date of results return
□ Tested on site	□ RDT antigen	□ positive □ negative	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_]
□ Referred to:	□ RDT antibody	□ positive □ negative	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_]
_____	□ PCR (e.g., GXP)	□ positive □ negative	[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_]

Is an additional test required? □ YES □ NO Next date of testing: DD/ MM/ YYYY

If you have questions, conact the Ministry of Health Public Health Emergency Operations Center (PHEOC) at 0800203033 or 0800100066