The Republic of Uganda

Ministry of Health:
Laboratory investigation form for Coronavirus Disease (COVID-19)

Date of sample collection: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_]	Unique Lab ID: ☐	Patient Prioritization level **Level 1** ☐ **Level 2** ☐ **Level 3** ☐ **Level 4** ☐	Bar code	Serial #:

Preliminary information

1. Where was the sample collected? Swabbing district: _____ ☐ Home ☐ Health facility (specify): _____ ☐ Point of entry (specify): _____

2. Who is being tested? ☐ Case ☐ Contact ☐ Point-of-entry ☐ Traveler ☐ Alert ☐ Health worker ☐ Postmortem ☐ Voluntary ☐ School/congregate testing

☐ Event Based Surveillance ☐ RDT confirmatory using PCR ☐ VIP ☐ Other: _____ (Receipt # for travelers & voluntary testing: _____)

3. If traveler, was traveler going in or out of Uganda? ☐ Into Uganda ☐ Out of Uganda **specify country?**

4. if health worker, Reason for health care worker (HW) testing? ☐ Routine exposure ☐ Quarantine ☐ Other _____ **HW's facility:**

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

Section 1: Patient information

1.1 Surname _____ 1.2. First name _____ 1.3. Sex ☐ M ☐ F

1.4. DOB: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_] or estimated age: [___][___] years. If <1 year, [___][___] months

1.5. Nationality _____ **1.6** NIN or Passport # (compulsory for travelers): _____

1.7. Address: Village _____ Parish _____ Sub-county _____ District _____

1.8. Patient phone #: _____ **1.9** Next-of-kin: _____ Phone #: _____

1.10. For Truck drivers: Vehicle Number plate: _____ Truck destination: _____

1.11. Vaccinated? ☐ Yes ☐ No 1.12 Type: ☐ AZ ☐ Other, specify: _____ ☐ Don't Know 1.13. Doses received: ☐ 1 ☐ 2 1.14. Date of last dose: _____

Section 2: Clinical Information

2.1. Is/was patient symptomatic? ☐ Yes ☐ No ----------> If No, skip to Section 3 (Specimen collection information)

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

2.3. Symptoms: ☐ Cough ☐ Fever ☐ Sore throat ☐ Shortness of breath ☐ Headache ☐ loss of smell and/ or taste ☐ Chest pain ☐ Runny nose ☐ Chills ☐ General weakness

Other, specify: _____ **2.4. Does patient have any known underlying conditions:** ☐ Yes ☐ No. **If yes, specify condition**

☐ Cardiovascular disease ☐ Neurological disease ☐ Renal disease ☐ Chronic lung disease ☐ Liver disease ☐ Malignancy, specify: _____ Other, specify: _____

Section 3: Specimen collection information **Sample Collected by:** _____ **Collector's facility** _____ **Phone:** _____

3.1. Specimen type	3.2 Date of specimen collection	3.3 Collection Time	3.4. Test requested	3.5. Was specimen referred?
☐ NP swab ☐ OP swab ☐ Blood ☐ Other:	[D][D]/[M][M]/[Y][Y][Y][Y]			

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

Tester's phone # _____ Tester's facility: _____

4.1. Test	4.2. Results	4.3. Date and time of results	4.4 Tester's Signature	4.5 Remarks
☐ RDT antigen	☐ Positive ☐ Negative	[D][D]/[M][M]/[Y][Y][Y][Y]		
☐ RDT antibody	☐ Positive ☐ Negative	[_H_][_H_]/[_M_][_M_]		

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4.6 Is an additional test required? ☐ YES ☐ NO **4.7 What test?** ☐ Genomic Sequencing ☐ PCR ☐ Others _____ Next date of testing: DD / MM / YYYY

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Section 5: Provisional Covid19 Results (client copy): Filled in by tester — Facility Name _____ Unique Lab ID: _____ Serial #:

5.1 Patient Surname — **5.2** Patient first name: — **5.3** Tester's phone #:

5.4 Tester's name — 5.5 Tester's Facility — 5.6 Tester's Signature

5.7 Specimen:	5.8 Test	5.9 Results	5.10 Date and time of results
☐ NP swab ☐ OP swab ☐ Blood ☐ Other:	☐ RDT antigen ☐ RDT antibody	☐ Positive ☐ Negative ☐ Positive ☐ Negative	[D][D]/[M][M]/[Y][Y][Y][Y] [_H_][_H_]/[_M_][_M_]

For results' related questions, contact the MOH CPHL at 0800221100 or MOH Public Health Emergency Operations Center at 0800203033