For sending Clinical samples of following tests enclosed requisition format is to be filled and send to Viral Research and Diagnostic Laboratory (VRDL), Department of Microbiology, mahatma Gandhi Memorial Medical College, A. B. Road, Indore (M.P.) 452001

S.NO.	Name of Test	Type of Sample to be send to VRDL	
1	Influenza Virus (Real Time PCR)	Throat Swab in VTM (0-7 days)	
2	Dengue NS-1 Ag ELISA	Serum (0-7 days)	
3	Dengue IgM ELISA	Serum Sample (> 7 days)	
4	CHIKUNGUNYA IgM ELISA	Serum Sample (> 7 days)	
5	Japenese Encephalitis IgM ELISA	Serum Sample	

Anita Mutha

डॉ. अनीता मूथा
प्रोफेसर एवं विभागाध्यक्ष
माइक्रोबायोलॉजी विभाग
म.गा.स्म. चिकित्सा महा. इंदौर

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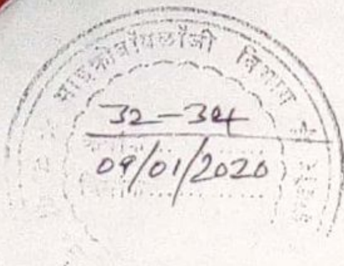

DEPARTMENT OF MICROBIOLOGY
M.G.M. MEDICAL COLLEGE, INDORE

Date: 09/01/2020

To,

The Dean & CEO,

MGM Medical College, Indore M.P.

Subject: Regarding upload the Viral research and Diagnostic Laboratory (VRDL) requisition form format on MGM Medical College Indore website.

Respected Madam,

In connection with above mentioned subject VRDL requires the prescribed filled requisition form format along with each samples for testing in our laboratory which is mandatory for VRDL-DHR ICMR project, since we have to fill all data in online DHR website.

Hence requesting you to give permission to upload the requisition form format on college website, so that concerned staff can download the requisition form format and can send samples with this requisition form for smooth conduction of work.

Thanking You
Best regards

Anita Mutha

Dr. Anita Mutha
Professor and Head, P.I. VRDL
Department of Microbiology
MGMMC, Indore MP

Enclosure: VRDL requisition form (CRF).

Copy to:

1. Superintendent, MYH, Indore MP
2. Nodal officer of Swine flu MYH Indore MP

Gen.
Permitted.
9/1/2020.

Dr. Anita Mutha
Professor and Head, P.I. VRDL
Department of Microbiology
MGMMC, Indore MP

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MAHATMA GANDHI MEMORIAL MEDICAL COLLEGE, INDORE
DHR-ICMR Virus Research and Diagnostic Laboratory Network (Ver 3.0)

A. Identification Section

Lab code | | | | Year | | | Patient ID *(issued by VRDL)* | | | | |

1.Sample Origin

Outbreak / disease cluster (Referred by Public Health Authorities)....... □ (go to page 2)

Outbreak / disease cluster (investigated by VRDL.................................. □ (go to page 2)

Date (DD/MM/YY) : □□/□□/□□

Outbreak : Investigation date

Medical college/Ref.Hosp. : Patient Visit date (OP) / Admission date(IP)

B. Patient Information

2. Patient name			
3. S/o D/o W/o		4. Age in completed years :	*For Infants* months / days
5. Sex : *Male* □ *Female* □		6. Contact Number :	
7. Patient Address:	Village/Town :	Taluk/Tehsil :	District :
	Pin Code :	State :	Rural / Urban / NK :
8. Patient type	*a. In-patient* □ *b. Out-patient* □	9. Hospital OP/IP number :	
10. Name of clinician:		11. Clinician's Contact number :	
12. Referral Hospital name:			

C. Clinical Details (Tick all that apply)

13. Date of onset of illness (*DD/MM/YY*) :

14. Duration of illness (in days) :

Syndromes	Associated Symptoms			
15. Diarrhoea □	*1. Fever* □	*2. Diarrhoea* □	*3. Dysentery* □	
	4. Pain in abdomen □	*5. Vomiting* □	*6. Others (specify)* □	
16. Respiratory □	*1. Fever* □	*2. Sore throat* □	*3. Cough* □	*4. Rhinorrhoea* □
	5. Breathlessness □	*6. Others (Specify)* □		
17. Fever of Unknown Origin □	*1. Fever* □	*2. Any localizing symptoms* □		
18. Rash □	*1. Fever* □	*2. Macular* □	*3. Papule* □	
	4. Maculo-papular □	*5. Eschar* □	*6. Pustule* □	
	7. Bullae □	*8. Others (Specify)* □		
19. Jaundice □	*1. Fever* □	*2. Jaundice* □	*3. Dark urine* □	*4. Hepatomegaly* □
	5. Nausea □	*6.Vomiting* □	*7. Abdominal pain/discomfort* □	
20. Encephalitis / Meningitis □	*1. Fever* □	*2. Irritability* □	*3. Increased Somnolence* □	
	4. New onset of Seizures □	*5. Neck rigidity* □	*6. Altered sensorium* □	
	7. Change in mental status □	*8. Others (Specify)* □		
21. Hemorrhagic Fever □	*1. Fever* □	*2. Rigors* □	*3. Headache* □	
	4. Chills □	*5. Malaise* □	*6. Arthralgia* □	
	7. Myalgia □	*8. Haemorrhagic manifestations* □		
	9. Retro-orbital pain □	*10. Others (Specify)* □		
22. Conjunctivitis □	*1. Fever* □	*2. Redness* □	*3. Discharge* □	*4. Crusting* □
23. Other Syndrome □	specify			
24. Provisional diagnosis :		25. Investigations Requested :		

D. Epidemiological Details

26.Presence of similar case in the house	*Yes* □ *No* □
27.Presence of similar case/s in the village/locality	*Yes* □ *No* □
28.History of travel in last 10 days	*Yes* □ *No* □
	If Yes, place visited

Consent/Assent:
I am explained and have understood that the sample collected for the diagnosis can be used for diagnosis of other viral agents for research purpose and will aid in understanding and mitigating these diseases. I have no objection for this since my identity will be kept confidential. I am willingly participating in the study.

Name of the person filling form :

Patient/Guardian Signature/Thumb Impression

Signature of person filling form :

Go to Section F (Details of sample collection) in Page 2

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MAHATMA GANDHI MEMORIAL MEDICAL COLLEGE, INDORE

DHR-ICMR Virus Research and Diagnostic Laboratory Network (Ver 3.0)

<u>To be filled only for Patients/samples from *Outbreak**</u>

*(samples sent by PHC/CHC/Dist. Health authorities and investigated by VRDL for confirmation of Outbreak/disease cluster)

E. Patient Information (to be filled by VRDL)

1. Patient name

3. Age in completed years : ☐☐ *For Infants* *months* ☐☐ *days* ☐☐ | 2. S/o D/o W/o | 4. Sex : *Male* ☐ *Female* ☐

5. Patient Address: Village/Town : | District : | Sub Centre : | PHC/CHC : | Pin Code : | State : | Rural / Urban / NK :

Contact details of the official referring the samples from outbreak: Name: Ph:

6. Outbreak Number *(issued by VRDL)* ☐ ☐

7. Date of sample collection : ☐☐/☐☐/☐☐☐☐

8. Date of Onset of symptoms: ☐☐/☐☐/☐☐☐☐

9. Total number of patients from whom samples are collected:

10. Patient Number within the outbreak :

11. Which of the following best describe the clinical presentation? *(Tick most appropriate option)*

a. Fever with rash (suspected measles/rubella) ☐	*b. Fever with rash, arthralgia (suspected dengue)* ☐
c. Fever with arthralgia (suspected Chikungunya) ☐	*d. Fever with respiratory symptoms (suspected influenza)* ☐
e. Fever with jaundice (suspected HAV/HEV) ☐	*f. Fever with neurological symptoms (suspected JE)* ☐
g. Fever with hemorrhagic manifestations ☐	*h. Acute diarrhoeal disease* ☐
i. Conjunctivitis ☐	*j. Gastroenteritis (probably food borne)* ☐
k. Acute flaccid paralysis ☐	*l. Others (Specify)* ☐

12. Provisional diagnosis :

13. Investigations Requested :

F.Details of Sample Collection (Tick all that apply)

Type of samples	Blood-Plasma(P)	Blood-Serum(S)	CSF(C)	NP Swab (N)	Throat swab (T)	Rectal swab (R)	Faeces (F)	Urine (U)	Others (specify) (O)
Tick (√) for the samples collected									
Date of collection									

ONLY FOR LABORATORY USE

G.Laboratory Results

Sl. No.	Virus *JE / Dengue / Chik / Rota / Measles..........*	Date of Testing (DD/MM/YYYY)	Sample Type *Plasma / Serum / CSF / NP Swab / Throat swab / Rectal swap / Faeces / Urine...........*	Test done *IgM / IgG / PCR / RTPCR / IFA / NT / HA / HI / Antigen detection / Virus isolation.........*	Result *Positive (+ ve) Negative (- ve) Equivocal*
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Sample sent to higher lab for further investigations	Yes	No

Name of the Technician :

Name of the lab in-charge :

Date :

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