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 le☐l 1 le☐l 2 le☐l 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 name: _____ 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_]		

Tear Here

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: 5.4 Tester's phone #:

5.3 Tester's name 5.5 Tester's facility: 5.6 Tester's Signature:

5.6 Specimen:	5.7 Test	5.8 Results	5.9 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