Ezra Long Laboratory
Owen King European Union Hospital
Millennium Heights Medical Complex, Millennium Highway,
Castries, St. Lucia W.I. LC04 305
Tel: 1-758-458-6734/6735/6740. Email: ezralonglab@mhmc.lc

Millennium Heights Medical Complex

1.Patient Information

Last Name: _____
First Name: _____
Patient ID: _____
Gender ☐ M ☐ F **Age:** ___ ☐ Years ☐ Months
Date of Birth (*dd/mm/yyyy*): _____
Address:
Street/Area: _____
Village/Town/ City/Parish: _____
Country: _____
Tel: _____
Email: _____
Occupation: _____

2.Referring Doctor

Name: _____
Reporting Address: _____
_____
Tel: _____
Email: _____

3.Provisional Diagnosis, Additional Notes

Travel History: _____
Risk Factors: _____
Use the back of the form to note other relevant clinical information.

4.Case/Specimen Status

☐ Single Case ☐ Outbreak ☐ Survey ☐ Unkwn

5.Date of Onset of Illness

dd/mm/yyyy: _____

6.Outcome

Hospitalized? ☐Y ☐N; Died? ☐Y ☐N

7.Signs and Symptoms (Check all that apply)

☐ Fever→Temp: _____→ Onset: dd/mm/yyyy: _____
☐ Rash→Location: _____ Onset: dd/mm/yyyy: _____
☐ Pain→Location: _____Onset:dd/mm/yyyy:_____
☐ Hemorrhagic symptoms →Describe_____

☐ Altered mental state	☐ Genital discharge
☐ Chills	☐ Hepatomegaly
☐ Circulatory collapse	☐ Respiratory, Upper
☐ Conjunctivitis	☐ Respiratory, Lower
☐ Convulsions	☐ Vomiting
☐ Coryza	**Chronic Conditions:**
☐ Cough	☐ Autoimmune disease
☐ Diarrhea, Acute	☐ Connective tissue disorder
☐ Diarrhea, Chronic	☐ Lymphoproliferative disorder
☐ Failure to thrive	☐ Transplant recipient/donor
☐ Jaundice	☐ Immunocompromised
☐ Neck stiffness	☐ HIV + ve: → ART Drug Info:
☐ Lymphadenopathy	_____
☐ Kernig's sign	_____
☐ Paralysis	
☐ Weight loss	☐ Other (Specify):
☐ Weakness of limb	

8.Syndromic Classification (Check all that apply)

☐ AFP ☐ Fever & Hemorrhagic
☐ Gastroenteritis ☐ Fever (undifferentiated)
☐ Fever & neurologic ☐ Fever & Rash
☐ Fever & Respiratory or Acute Respiratory infection

9. Antigen Test Status

Performed: ☐ Yes ☐ No **Test Brand:** _____
If yes, Result: ☐ Negative ☐ Positive

TEST PANEL:

☐ LEPTOSPIROSIS	☐ CHIK-V	☐ VIRAL LOAD	☐ MEASLES
☐ COVID-19	☐ ZIKA	☐ ROTA VIRUS	☐ RUBELLA
☐ INFLUENZA A	☐ DENGUE	☐ NOROVIRUS	☐ MONKEYPOX
☐ INFLUENZA B	☐ RESPIRATORY SYNCYTITIAL VIRUS		
☐ OTHER (Specify):			

SPECIMEN TYPE:

☐ Blood	☐ Stool
☐ Fluid	☐ Urine
☐ Nasopharyngeal Swab	☐ Lesion Swab
☐ OTHER (Specify):	

Date of collection: _____ **Time**: ___: ___ ☐ am ☐ pm **Specimen #** (eg:1st/2nd/3rd) _____
dd/mm/yyyy

Collected By: _____ _____
Name **Signature**

LABORATORY USE ONLY

Sample Received By: _____ _____ **Date**: _____ **Time**: ___: ___ ☐ am ☐ pm
(Name) **(Signature)** **dd/mm/yyyy**

☐ **Accepted** ☐ **Rejected**

Reason for Rejection: _____

Place specimen label here