Rota Virus Lab Surveillance Form

Health Protection Agency

Male', Maldives

HPA-SUR-U00072-F-2019-1

Reporting Institution:

Instructions:

1. This form should be completed for **each suspected or confirmed Rota Virus** case.
2. All cases must have samples collected and send to IGMH lab for testing.
3. Attach copies of documents showing evidence of Rota Virus vaccination if any.

Outbreak number and ID

Only in outbreaks (HPA use only)

Case definition for Rota Virus lab surveillance

Child aged 0-59 months, admitted for treatment of acute (< 14 days) watery gastroenteritis/diarrhea and/or one or more episodes of vomiting in 24 hours

Exclusions: children with bloody diarrhea

Case identification

1-Patient ID card Number Foreigners Passport number	**2-Date of Birth: ___/____/_____**	**4- Age:** (yy) If in months write as a fraction, m/12 e.g. 4 months is 4/12	**5-Sex:** ☐ Male or ☐ Female
3- Name of the patient:	**Parent/Guardian:**	**Contact Number:**	

Permanent Address: **Atoll:** **Island:**

Usual place of residence: **Atoll:** **Island:**

Clinical Information

Date onset of diarrhea: ___/____/_____ (dd/mm/yy yy) **Admission Date**: ___/____/____(dd/mm/yy yy)

1. Diarrhea ☐Yes ☐No Number of episodes/24hours _____ Duration of diarrhea_____
2. Fever (>100F or 38 ºC) ☐Yes ☐No
3. Vomiting ☐Yes ☐No Number of episodes/24hours _____ Duration of vomiting_____

Vaccination History

Rota virus vaccination status

☐Yes ☐No ☐Do not know

Number of doses:	Date of 1st dose: / /	Date of 2nd dose: / /

Form filled by

Name of the Doctor:	**Designation:**
Date: / /	**Sign:**

Sample Collection (To be filled by doctor/nurse)

Date of collection (should be within 48 hours of admission) / /	**Date (sample send to IGMH lab)** / /	**Name of facility:**	**Form filled by:**
Designation:		**Signature**	

To be filled by the Lab staff

IGMH Lab ID:	**Date (sample received by IGMH lab):** / /	**Adequate sample (5ml) ☐Yes ☐No**
Date of Testing: / /		
Results: ☐+ve ☐-ve ☐ equivocal		
Date of result: / /		
Filled by (Lab staff) Name:	**Designation:**	**Signature:**
Date of result to HPA: / /	Contact number at IGMH Lab 3335122	

Outcome to be filled by HPA

Date of discharge/death: / /

Name	**Designation:**
Date: / /	**Sign: _____**