



RDT Based Cholera Surveillance Program

Request for Stool/Rectal Swab Culture for Vibrio Cholera O1/O139

Section A: Request made by

Name of health facility and address:

Date of request: -- / -- / ---- (DD MM YYYY)

Name of referring health worker:

Post:

Phone/Mobile number:

E-mail:

Section B: Patient Details:

Name of patient: Patient ID:

Sex: Male Female

Age:

Mobile no.....

Address: Municipality/rural municipality..... Ward no.

Tole/village.....

Province:

Date of onset of illness: / /

Patient outcome at time of request: Hospitalized Discharged Death

Referred Others (specify).....

Section C: Specimen Details

Stool in Cary Blair Rectal swab in Cary Blair

Stool in Alkaline peptone water If Other, Specify.....

Date of sample collection:

Stool consistency/formation (select one): Solid Semi-solid Liquid

Stool appearance (select all that apply) at the time of collection:

Rice-water Bloody Slimy Other (specify):

Was an RDT performed on the same specimen? Yes No

Result of RDT :

Negative

Positive V. cholerae O1

Positive V. cholerae O1 & 139

Positive V. cholerae O139

Name and Lot no. of RDT kit used:

Section D: To be completed by the receiving laboratory

Recipient laboratory (name/ address)

Name and Post of lab personnel receiving sample:

Date and time of specimen received: / / Time: AM/PM

Condition of specimen/packaging/documentation:

Adequate

Not adequate

If not adequate (specify)