

LAB USE ONLY:
LID BARCODE

BOTSWANA HARVARD
HIV REFERENCE LABORATORY

PRINCESS MARINA HOSPITAL
GABORONE, BOTSWANA * TEL 3902671 EXT2126

BHP142

HR965

STOOL SAMPLE (STORAGE)

INSTRUCTIONS: PLEASE PRINT IN BLOCK LETTERS. COMPLETE SECTIONS 1-4 ONLY AND SUBMIT THIS FORM WITH A SAMPLE.
SAMPLE MUST BE RECEIVED BEFORE 2:00 PM MONDAY-FRIDAY.

SECTION 1: PATIENT INFORMATION

Participant ID:

B	1	4	2	-	0	4	0	9	9									-			
---	---	---	---	---	---	---	---	---	---	--	--	--	--	--	--	--	--	---	--	--	--

EDC Requisition ID(if required):

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

P. Initials

--	--	--

Gender

--

Visit

--	--	--	--	--	--

Date of Birth

		/			/						
--	--	---	--	--	---	--	--	--	--	--	--

dd

mm

yyyy

SECTION 2: SPECIMEN INFORMATION

Date Specimen Drawn (DD/MM/YYYY)

		/			/				
--	--	---	--	--	---	--	--	--	--

dd

mm

yyyy

Time Specimen Drawn

		:		
--	--	---	--	--

hh

mm

Tube type

Cryovials	1ml
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SECTION 3: SITE INFORMATION

Site Code

0	0	4	0
---	---	---	---

Billing Code

B	H	P	1	4	2
---	---	---	---	---	---

SECTION 4: CLINICAL INFORMATION

Study Coordinator

Dr Kate Powis

Phone: 76485309/ 3907619

BHP142 FLOURISH STUDY

Botswana- Harvard Partnership

Name and Initials of Clinician

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SECTION 5: SITE REQUISITION INFORMATION

1. Number of stool vials collected:

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SECTION 6: LABORATORY USE ONLY

(to be completed by laboratory technician)

1. Sample Reference Number (if barcode not used)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

2. Was Sample processed and stored?

☐ Yes

☐ NO

(If Yes, go to Question 3. If No complete question 2 then STOP)

3. If NO results, select PRIMARY reason results not obtained?

☐ Sample unsatisfactory to run test(e.g. volume, tube type, condition)

☐ Technical problems at the lab(e.g. staff or equipment)

☐ Other Specify _____

3. Date assay performed

		/			/						
--	--	---	--	--	---	--	--	--	--	--	--

dd

mm

yyyy

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Stamp OR Initials of validating technician

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Stamp OR Initials of lab technician

LAB USE ONLY:
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VIRAL LOAD

INSTRUCTIONS: PLEASE PRINT IN BLOCK LETTERS. COMPLETE SECTIONS 1-4 ONLY AND SUBMIT THIS FORM WITH A SAMPLE.
SAMPLE MUST BE RECEIVED BEFORE 2:00 PM MONDAY-FRIDAY.

SECTION 1: PATIENT INFORMATION

Participant ID:

B	1	4	2	-	0	4	0	9	9									-				
---	---	---	---	---	---	---	---	---	---	--	--	--	--	--	--	--	--	---	--	--	--	--

EDC Requisition ID(if required):

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

P. Initials

--	--	--

Gender

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Visit

--	--	--	--	--	--

Date of Birth

		/			/						
dd		mm				yyyy					

SECTION 2: SPECIMEN INFORMATION

Date Specimen Drawn (DD/MM/YYYY)

		/			/				
dd		mm				yyyy			

Time Specimen Drawn

		:		
hh		mm		

Tube type

EDTA	4.0 ml
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SECTION 3: SITE INFORMATION

Site Code

0	0	4	0
---	---	---	---

Billing Code

B	H	P	1	4	2
---	---	---	---	---	---

SECTION 4: CLINICAL INFORMATION

Study Coordinator
Dr Kate Powis
Phone: 76485309/ 3907619
BHP142 FLOURISH STUDY
Botswana- Harvard Partnership

Name and Initials of Clinician

--	--	--

SECTION 6: SITE REQUISITION INFORMATION

4. Number of vials of plasma stored

--

5. Comment

SECTION 5: LABORATORY USE ONLY

(to be completed by laboratory technician)

1. Sample Reference Number (if barcode not used)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

2. Was Sample processed and stored?

☐ Yes

☐ NO

(If Yes, go to Question 3. If No complete question 2 then STOP)

3. If NO results, select PRIMARY reason results not obtained?

☐ Sample unsatisfactory to run test(e.g. volume, tube type, condition)

☐ Technical problems at the lab(e.g. staff or equipment)

☐ Other Specify _____

3. Date assay performed

		/			/				
dd		mm				yyyy			

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Stamp OR Initials of validating technician

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Stamp OR Initials of lab technician

LAB USE ONLY:
LID BARCODE

DNA PCR

INSTRUCTIONS: PLEASE PRINT IN BLOCK LETTERS. COMPLETE SECTIONS 1-4 ONLY AND SUBMIT THIS FORM WITH A SAMPLE.
SAMPLE MUST BE RECEIVED BEFORE 2:00 PM MONDAY-FRIDAY.

SECTION 1: PATIENT INFORMATION

Participant ID:

B	1	4	2	-	0	4	0	9	9									-				
---	---	---	---	---	---	---	---	---	---	--	--	--	--	--	--	--	--	---	--	--	--	--

EDC Requisition ID(if required):

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P. Initials

--	--	--

Gender

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Visit

--	--	--	--	--	--

Date of Birth

		/			/				
dd			mm			yyyy			

SECTION 2: SPECIMEN INFORMATION

Date Specimen Drawn (DD/MM/YYYY)

		/			/				
dd			mm			yyyy			

Time Specimen Drawn

		:		
hh			mm	

Tube type

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SECTION 3: SITE INFORMATION

Site Code

0	0	4	0
---	---	---	---

Billing Code

B	H	P	1	4	2
---	---	---	---	---	---

SECTION 4: CLINICAL INFORMATION

Study Coordinator
Dr Kate Powis
Phone: 76485309/ 3907619
BHP142 FLOURISH STUDY
Botswana- Harvard Partnership

Name and Initials of Clinician

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SECTION 6: LABORATORY USE ONLY

4. Number of vials of plasma stored

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5. Comment

SECTION 5: LABORATORY USE ONLY

(to be completed by laboratory technician)

1. Sample Reference Number (if barcode not used)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

2. Was Sample processed and stored?

☐ Yes

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(If Yes, go to Question 3. If No complete question 2 then STOP)

3. If NO results, select PRIMARY reason results not obtained?

☐ Sample unsatisfactory to run test(e.g. volume, tube type, condition)

☐ Technical problems at the lab(e.g. staff or equipment)

☐ Other Specify _____

3. Date assay performed

		/			/				
dd			mm			yyyy			

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Stamp OR Initials of validating technician

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Stamp OR Initials of lab technician

LAB USE ONLY:
LID BARCODE

RECTILE SWAB

INSTRUCTIONS: PLEASE PRINT IN BLOCK LETTERS. COMPLETE SECTIONS 1-4 ONLY AND SUBMIT THIS FORM WITH A SAMPLE.
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EDC Requisition ID(if required):

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P. Initials

--	--	--

Gender

--

Visit

--	--	--	--	--	--

Date of Birth

		/			/						
dd		mm				yyyy					

SECTION 2: SPECIMEN INFORMATION

Date Specimen Drawn (DD/MM/YYYY)

		/			/				
dd		mm				yyyy			

Time Specimen Drawn

		:		
hh		mm		

Tube type

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SECTION 3: SITE INFORMATION

Site Code

0	0	4	0
---	---	---	---

Billing Code

B	H	P	1	4	2
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SECTION 4: CLINICAL INFORMATION

Study Coordinator
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Botswana- Harvard Partnership

Name and Initials of Clinician

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SECTION 6: SITE REQUISITION INFORMATION

4. Number of vials stored

--

5. Comment

SECTION 5: LABORATORY USE ONLY

(to be completed by laboratory technician)

1. Sample Reference Number (if barcode not used)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

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3. Date assay performed

		/			/				
dd		mm				yyyy			

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Stamp OR Initials of validating technician

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Stamp OR Initials of lab technician

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INFANT PL CYTOKINES

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Participant ID:

B	1	4	2	-	0	4	0	9	9									-				
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EDC Requisition ID(if required):

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P. Initials

--	--	--

Gender

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Visit

--	--	--	--	--	--

Date of Birth

		/			/						
dd			mm			yyyy					

SECTION 2: SPECIMEN INFORMATION

Date Specimen Drawn (DD/MM/YYYY)

		/			/				
dd			mm			yyyy			

Time Specimen Drawn

		:		
hh			mm	

Tube type

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Botswana- Harvard Partnership

Name and Initials of Clinician

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SECTION 6: SITE REQUISITION INFORMATION

4. Number of vials stored

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5. Comment

SECTION 5: LABORATORY USE ONLY

(to be completed by laboratory technician)

1. Sample Reference Number (if barcode not used)

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		/			/				
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Stamp OR Initials of validating technician

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Stamp OR Initials of lab technician

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HIV REFERENCE LABORATORY
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GABORONE, BOTSWANA * TEL 3902671 EXT2126

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HR965

CD4

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P. Initials

--	--	--

Gender

--

Visit

--	--	--	--	--	--

Date of Birth

		/			/				
--	--	---	--	--	---	--	--	--	--

dd mm yyyy

SECTION 2: SPECIMEN INFORMATION

Date Specimen Drawn (DD/MM/YYYY)

		/			/				
--	--	---	--	--	---	--	--	--	--

dd mm yyyy

Time Specimen Drawn

		:		
--	--	---	--	--

hh mm

Tube type

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3. Date assay performed

		/			/				
--	--	---	--	--	---	--	--	--	--

dd mm yyyy

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Stamp OR Initials of validating technician

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Stamp OR Initials of lab technician

