LAB USE ONLY:
LID BARCODE

BOTSWANA HARVARD
HIV REFERENCE LABORATORY

PRINCESS MARINA HOSPITAL
GABORONE, BOTSWANA * TEL 3902671 EXT2126

BHP142

HR965

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

Particiant 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 ☐ EDTA 1ml ☐ DBS

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: LABORATORY USE ONLY

1. Number of vials ~~plasma~~ stored: ☐

2. Comment

_____

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 unsatisfatory to run test(e.g. volume, tube type, condition)

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

☐ Other Specify _____

4. Date assay performed

dd / mm / yyyy

Stamp OR Initials of validating technichian

Stamp OR Initials of lab technichian

LAB USE ONLY:
LID BARCODE

BOTSWANA HARVARD
HIV REFERENCE LABORATORY

PRINCESS MARINA HOSPITAL
GABORONE, BOTSWANA * TEL 3902671 EXT2126

BHP142

HR965

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

Particiant 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 EDTA 4.0 ml

Increase Font for Volume.

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: LABORATORY USE ONLY

1. Number of vials ~~plasma~~ stored:
2. Comment

_____

SECTION 6: LABORATORY USE ONLY

(to be completed by laboratory technician)

1. Sample Reference Number (if barcode not used)

Stamp OR Initials of validating technichian

Stamp OR Initials of lab technichian

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 unsatisfatory to run test(e.g. volume, tube type, condition)

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

☐ Other Specify _____

4. Date assay performed

dd / mm / yyyy

LAB USE ONLY:
LID BARCODE

BOTSWANA HARVARD
HIV REFERENCE LABORATORY

PRINCESS MARINA HOSPITAL
GABORONE, BOTSWANA * TEL 3902671 EXT2126

BHP142

HR965

PLASMA CYTOKINES

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

Particiant 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 EDTA 1ml

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: LABORATORY USE ONLY

1. Number of vials plasma stored:
2. Comment

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 unsatisfatory to run test(e.g. volume, tube type, condition)

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

☐ Other Specify _____

4. Date assay performed

dd / mm / yyyy

Stamp OR Initials of validating technichian

Stamp OR Initials of lab technichian

LAB USE ONLY:
LID BARCODE

BOTSWANA HARVARD
HIV REFERENCE LABORATORY

PRINCESS MARINA HOSPITAL
GABORONE, BOTSWANA * TEL 3902671 EXT2126

BHP142

HR965

CHEMISTRY

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

Particiant 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 **Tube type**

hh : mm SST 3.5ml

Increase font for volume

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 5: SITE REQUISITION INFORMATION (CLINIC ONLY) USE

Tests:

- ☐ Fasting Lipids
- ☐ AST
- ☐ ALT
- ☐ Creatinine
- ☐ Albumin

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 unsatisfatory to run test(e.g. volume, tube type, condition)
- ☐ Tachnical problems at the lab(e.g. staff or equipment)
- ☐ Other Specify _____

4. Date assay performed

dd / mm / yyyy

SECTION 6: LABORATORY USE ONLY

1. Number of vials stored: ☐

2. Comment

3. _____

Stamp OR Initials of validating technichian

Stamp OR Initials of lab technichian

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

Particiant 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

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 5: SITE REQUISITION INFORMATION (CLINIC USE ONLY)

1. Number of stool vials collected: [ ]

2. Comment

SECTION 6: LABORATORY USE ONLY

(to be completed by laboratory technician)

1. Sample Reference Number (if barcode not used)

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Stamp OR Initials of validating technichian

Stamp OR Initials of lab technichian

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 unsatisfatory to run test(e.g. volume, tube type, condition)

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

☐ Other Specify _____

4. Date assay performed

[ ][ ] / [ ][ ] / [ ][ ][ ][ ]

dd mm yyyy

LAB USE ONLY:
LID BARCODE

BOTSWANA HARVARD
HIV REFERENCE LABORATORY

PRINCESS MARINA HOSPITAL
GABORONE, BOTSWANA * TEL 3902671 EXT2126

BHP142

HR965

RECTAL SWAB (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

Particiant 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

[ ][ ] : [ ][ ] SWAB
hh mm

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 5: SITE REQUISITION INFORMATION (CLINIC USE ONLY)

1. Number of swabs collected: [ ]
2. Comment
2. _____

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 unsatisfatory to run test(e.g. volume, tube type, condition)

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

☐ Other Specify _____

4. Date assay performed

[ ][ ] / [ ][ ] / [ ][ ][ ][ ]
dd mm yyyy

Stamp OR Initials of validating technichian

Stamp OR Initials of lab technichian

LAB USE ONLY:
LID BARCODE

BOTSWANA HARVARD
HIV REFERENCE LABORATORY

PRINCESS MARINA HOSPITAL
GABORONE, BOTSWANA * TEL 3902671 EXT2126

BHP142

HR965

FBC

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

Particiant 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 EDTA 3ml

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: LABORATORY USE ONLY

1. Number of vials stored: [ ]

2. Comment

_____

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 unsatisfatory to run test(e.g. volume, tube type, condition)

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

☐ Other Specify _____

4. Date assay performed

[ ][ ] / [ ][ ] / [ ][ ][ ][ ]

dd mm yyyy

Stamp OR Initials of validating technichian

Stamp OR Initials of lab technichian

LAB USE ONLY:
LID BARCODE

BOTSWANA HARVARD
HIV REFERENCE LABORATORY

PRINCESS MARINA HOSPITAL
GABORONE, BOTSWANA * TEL 3902671 EXT2126

BHP142

HR965

LEAD

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

Particlant 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 **Tube type**

hh : mm EDTA 3ml

increase font size for volume

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: LABORATORY USE ONLY

1. Number of vials stored:
2. Comment

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 unsatisfatory to run test(e.g. volume, tube type, condition)

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

☐ Other Specify _____

4. Date assay performed

dd / mm / yyyy

Stamp OR Initials of validating technichian

Stamp OR Initials of lab technichian

LAB USE ONLY:
LID BARCODE

BOTSWANA HARVARD
HIV REFERENCE LABORATORY

PRINCESS MARINA HOSPITAL
GABORONE, BOTSWANA * TEL 3902671 EXT2126

BHP142

HR965

FBC

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

Particiant 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 EDTA 3ml

Increase font size

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: LABORATORY USE ONLY

1. Number of vials stored:
2. Comment

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 unsatisfatory to run test(e.g. volume, tube type, condition)

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

☐ Other Specify _____

4. Date assay performed

dd / mm / yyyy

Stamp OR Initials of validating technichian

Stamp OR Initials of lab technichian

LAB USE ONLY:
LID BARCODE

BOTSWANA HARVARD
HIV REFERENCE LABORATORY

PRINCESS MARINA HOSPITAL
GABORONE, BOTSWANA * TEL 3902671 EXT2126

BHP142

HR965

PLASMA 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

Particlant 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 EDTA 3ml

Increase Font Size

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: LABORATORY USE ONLY

1. Number of vials stored:
2. Comment

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 unsatisfatory to run test(e.g. volume, tube type, condition)

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

☐ Other Specify _____

4. Date assay performed

dd / mm / yyyy

Stamp OR Initials of validating technichian

Stamp OR Initials of lab technichian

LAB USE ONLY:
LID BARCODE

BOTSWANA HARVARD
HIV REFERENCE LABORATORY

PRINCESS MARINA HOSPITAL
GABORONE, BOTSWANA * TEL 3902671 EXT2126

BHP142

HR965

Separate – Make 2 templates

FASTING GLUCOSE & INSULIN

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.

- Insulin
- FASTING GLUCOSE
*Same tube type and volume

SECTION 1: PATIENT INFORMATION

Particiant 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 SST 5ml

Increase font size

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: LABORATORY USE ONLY

1. Number of vials stored: [ ]
2. Comment

_____

SECTION 6: LABORATORY USE ONLY

(to be completed by laboratory technician)

1. Sample Reference Number (if barcode not used)

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Stamp OR Initials of validating technician

Stamp OR Initials of lab technician

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 unsatisfatory to run test(e.g. volume, tube type, condition)

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

☐ Other Specify _____

4. Date assay performed

[ ][ ] / [ ][ ] / [ ][ ][ ][ ]
dd mm yyyy

LAB USE ONLY:
LID BARCODE

BOTSWANA HARVARD
HIV REFERENCE LABORATORY

PRINCESS MARINA HOSPITAL
GABORONE, BOTSWANA * TEL 3902671 EXT2126

BHP142

HR965

SERUM 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

Particiant 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 **Tube type**

: SST 5ml
hh mm

Increase font size

SECTION 3: SITE INFORMATION

Site Code **Billing Code**

0 0 4 0 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: LABORATORY USE ONLY

1. Number of vials stored:
2. Comment

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 unsatisfatory to run test(e.g. volume, tube type, condition)

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

☐ Other Specify _____

4. Date assay performed

/ /
dd mm yyyy

Stamp OR Initials of validating technichian

Stamp OR Initials of lab technichian

LAB USE ONLY:
LID BARCODE

BOTSWANA HARVARD
HIV REFERENCE LABORATORY

PRINCESS MARINA HOSPITAL
GABORONE, BOTSWANA * TEL 3902671 EXT2126

BHP142

HR965

CD4

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

Particiant 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 EDTA 4ml

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: LABORATORY USE ONLY

1. Number of vials stored:
2. Comment

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 unsatisfatory to run test(e.g. volume, tube type, condition)

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

☐ Other Specify _____

4. Date assay performed

dd / mm / yyyy

Stamp OR Initials of validating technichian

Stamp OR Initials of lab technichian

FLOURISH (BHP142) Infant Samples Delivery Checklist Document No: BHHRL/ 001FR078 Version 1	BOTSWANA HARVARD AIDS INSTITUTE PARTNERSHIP FOR HIV RESEARCH AND EDUCATION Botswana-Harvard HIV Reference Laboratory (BHHRL) Tel: +267 3902671; Fax: +267 3901284 lab.quality@bhp.org.bw

Site Code: ____________ Date : ______________ Page_____ of _____

IT IS FAINT WHEN PRINTED MAKE THE FONT THE SAME.

Instructions: Clinic: indicate with "X" both specimen and form sent in shaded boxes. Complete clinic portions above and below; Lab – indicate "X" specimen and form received white boxes and lab portions below. Provide clinic a copy	STOOL SAMPLE (STORAGE)		DNA PCR		RECTAL SWAB (STORAGE)		PLASMA CYTOKINES		FBC		FASTING GLUCOSE & Insulin		SERUM STORAGE		PLASMA STORAGE		LEAD		CHEMISTRY	
B 1 4 2 - 0 4 0 9 9 0 4 1 4 - 0 - 1 0	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s
	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s
B 1 4 2 - 0 4 0 9 9	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s
	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s
B 1 4 2 - 0 4 0 9 9	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s
	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s
B 1 4 2 - 0 4 0 9 9	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s
	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s
B 1 4 2 - 0 4 0 9 9	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s
	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s	f	s

Comments: ____

Site Clinic: ____________________ **Initials of site personnel completing this form:** __________
Initials of site personnel delivering specimens to the laboratory: __________ **Time of departure:** __________
Laboratory:
Time Specimens Received: __________ **Initials of laboratory staff receiving samples:** __________
Comments: ______________________________ **Date:** __________

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Site Code: ___________ Date : ___________ Page ____ of ____

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B	1	4	2	-	0	4	0	9	9	0	4	1	4	-	0		f	s	f	s	f	s
																	f	s	f	s	f	s
B	1	4	2	-	0	4	0	9	9								f	s	f	s	f	s
																	f	s	f	s	f	s
B	1	4	2	-	0	4	0	9	9								f	s	f	s	f	s
																	f	s	f	s	f	s
B	1	4	2	-	0	4	0	9	9								f	s	f	s	f	s
																	f	s	f	s	f	s
B	1	4	2	-	0	4	0	9	9								f	s	f	s	f	s
																	f	s	f	s	f	s

Comments: ___________

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Initials of site personnel delivering specimens to the laboratory: ___________ **Time of departure:** ___________
Laboratory:
Time Specimens Received: ___________ **Initials of laboratory staff receiving samples:** ___________
Comments: ___________ **Date:** ___________