

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):

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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

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

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**SECTION 5: SITE REQUISITION
INFORMATION (CLINIC USE ONLY)**

1. Number of stool vials collected:

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

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

☐ Other Specify _____

4. Date assay performed

		/			/				
dd			mm			yyyy			

--

Stamp OR Initials of validating technician

--

Stamp OR Initials of lab technician

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

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

<input type="checkbox"/>	<input type="checkbox"/>
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

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

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

☐ Other Specify _____

4. Date assay performed

		/			/				
dd			mm			yyyy			

--

Stamp OR Initials of validating technician

--

Stamp OR Initials of lab technician

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

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

		:			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

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**SECTION 5: SITE REQUISITION
INFORMATION (CLINIC USE ONLY)**

1. Number of swabs collected:

--

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

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

☐ Other Specify _____

4. Date assay performed

		/			/				
dd			mm			yyyy			

--

Stamp OR Initials of validating technician

--

Stamp OR Initials of lab technician

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

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

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

☐ Other Specify _____

4. Date assay performed

		/			/				
dd			mm			yyyy			

--

Stamp OR Initials of validating technician

--

Stamp OR Initials of lab technician

Stamp OR Initials of lab technician

BOTSWANA HARVARD
HIV REFERENCE LABORATORY

PRINCESS MARINA HOSPITAL
GABORONE, BOTSWANA * TEL 3902671 EXT2126

BHP142

HR965

LAB USE ONLY:
LID BARCODE

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

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	3ml
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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: 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 unsatisfactory to run test(e.g. volume, tube type, condition)

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

☐ Other Specify _____

4. Date assay performed

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

dd

mm

yyyy

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Stamp OR Initials of validating technician

--

Stamp OR Initials of lab technician

LAB USE ONLY:
LID BARCODE

BOTSWANA HARVARD
HIV REFERENCE LABORATORY
PRINCESS MARINA HOSPITAL
GABORONE, BOTSWANA * TEL 3902671 EXT2126

BHP142

HR965

FASTING GLUCOSE

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

SST	5ml
-----	-----

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

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

☐ Other Specify _____

4. Date assay performed

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

dd mm yyyy

--

Stamp OR Initials of validating technician

--

Stamp OR Initials of lab technician

BOTSWANA HARVARD
HIV REFERENCE LABORATORY

PRINCESS MARINA HOSPITAL
GABORONE, BOTSWANA * TEL 3902671 EXT2126

BHP142

HR965

LAB USE ONLY:
LID BARCODE

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.

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

SST	5ml
-----	-----

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

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

☐ Other Specify _____

4. Date assay performed

		/			/				
dd			mm			yyyy			

--

Stamp OR Initials of validating technician

--

Stamp OR Initials of lab technician

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

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

SST	5ml
-----	-----

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

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

☐ Other Specify _____

4. Date assay performed

		/			/				
dd			mm			yyyy			

--

Stamp OR Initials of validating technician

--

Stamp OR Initials of lab technician

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

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

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

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

☐ Other Specify _____

4. Date assay performed

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

dd

mm

yyyy

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Stamp OR Initials of validating technician

--

Stamp OR Initials of lab technician

BOTSWANA HARVARD
HIV REFERENCE LABORATORY

PRINCESS MARINA HOSPITAL
GABORONE, BOTSWANA * TEL 3902671 EXT2126

BHP142

HR965

LAB USE ONLY:
LID BARCODE

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

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

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

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

☐ Other Specify _____

4. Date assay performed

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

dd mm yyyy

--

Stamp OR Initials of validating technician

--

Stamp OR Initials of lab technician

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

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

SST	3.5ml
-----	-------

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 (CLINIC USE ONLY)

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

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Stamp OR Initials of validating technician

--

Stamp OR Initials of lab technician