

LAB USE ONLY:  
LID BARCODE

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

**BHP142**

**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

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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
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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 (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			

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Stamp OR Initials of validating technician

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Stamp OR Initials of lab technician



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**BHP142**

HR965

**VIRAL LOAD**

INSTRUCTIONS: PLEASE PRINT IN BLOCK LETTERS. COMPLETE SECTIONS 1-4 ONLY AND SUBMIT THIS FORM WITH A SAMPLE.  
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**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

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**

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Botswana- Harvard Partnership

Name and Initials of Clinician

--	--	--

**SECTION 6: RESULTS (if resulted manually)**

(to be completed by laboratory technician)

4. Was Abbott Platform assay used to obtain result?

☐ Yes ☐ NO

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

4. a.If NO, specify the test used

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

5. Quantifier code

- ☐ Equals  
☐ Grater than  
☐ Less than

6. Viral Load result in copies/mL

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

7. Log Viral Load result

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

8. Number of vials of Plasma stored

--	--

9. Comment

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**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)  
☐ Tachnical 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

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.

Stamp OR Initials of lab technician

dd / mm / yyyy

Stamp OR Initials of lab technician

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**BHP142**

HR965

**PLASMA CYTOKINES**

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**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

--

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

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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

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

## www

## mm

EDTA 4ml

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

--	--	--

## www

Stamp OR Initials of validating technician

Stamp OR Initials of lab technician

dd      mm      yyyy

Stamp OR Initials of lab technician



LAB USE ONLY:  
LID BARCODE

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

## www

## mm

EDTA 3ml

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

--	--	--

## www

Stamp OR Initials of lab technician

www

Stamp OR Initials of validating technician

Stamp OR Initials of lab technician

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**BHP142**

HR965

**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
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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**

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\_\_\_\_\_  
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

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.

dd

mm

www

Stamp OR Initials of validating technician

Stamp OR Initials of lab technician





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## www

## mm

Stamp OR Initials of lab technician