Child FLOURISH (BHP142)
* Caregiver 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 _____

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		DNA PCR		RECTAL SWAB		PLASMA CYTOKINES		FBC		Insulin		FASTING GLUCOSE		SERUM STORAGE		PLASMA STORAGE	
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
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
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
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
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

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:** ____________

FLOURISH (BHP142)
Child Samples Delivery Checklist
Document No: BHHRL/ 001FR078

Version 1

Botswana-Harvard HIV Reference Laboratory (BHHRL)
Tel: +267 3902671;
Fax: +267 3901284
lab.quality@bhp.org.bw

Site Code: _____ Date : _____ Page____ of ____

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

	WHOLE BLOOD EDTA (STORAGE)		WHOLE BLOOD SST (STORAGE)		ANTERIOR NASAL SWAB (STORAGE)		WHOLE BLOOD EDTA for HIV ELISA		QuantiFERO N-TB Gold Plus	
B 1 5 7 -	f	s	f	s	f	s	f	s	f	s
	f	s	f	s	f	s	f	s	f	s
B 1 5 7 -	f	s	f	s	f	s	f	s	f	s
	f	s	f	s	f	s	f	s	f	s
B 1 5 7 -	f	s	f	s	f	s	f	s	f	s
	f	s	f	s	f	s	f	s	f	s
B 1 5 7 -	f	s	f	s	f	s	f	s	f	s
	f	s	f	s	f	s	f	s	f	s
B 1 5 7 -	f	s	f	s	f	s	f	s	f	s
	f	s	f	s	f	s	f	s	f	s

B142 ??

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:** _____

LAB USE ONLY:
LID BARCODE

BOTSWANA HARVARD
HIV REFERENCE LABORATORY

PRINCESS MARINA HOSPITAL
GABORONE, BOTSWANA * TEL 3902671 EXT2126

BHP1

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)

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

BHP1

QuantiFERON-TB Gold Plus

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

Lithium Heparin (Green top) 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 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)

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 7: Results

☐ Negative

☐ Positive

☐ Borderline

☐ Invaild

_____

_____

_____

_____

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

HR96

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

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: 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: 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

LAB USE ONLY:
LID BARCODE

BOTSWANA HARVARD
HIV REFERENCE LABORATORY

PRINCESS MARINA HOSPITAL
GABORONE, BOTSWANA * TEL 3902671 EXT2120

BHP142

HR96

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 **Tube type**

hh : mm ☐ 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 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

Result section ??

LAB USE ONLY:
LID BARCODE

BOTSWANA HARVARD
HIV REFERENCE LABORATORY

PRINCESS MARINA HOSPITAL
GABORONE, BOTSWANA * TEL 3902671 EXT2126

BHP142

HR96

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

hh : mm SWAB

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

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

HR96

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 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

HR96

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 **Tube type**

hh : mm 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)

Stamp OR Initials of validating technician

Stamp OR Initials of lab technician

Result section ??

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

HR96

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

HR96

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

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

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

Results section

LAB USE ONLY:
LID BARCODE

BOTSWANA HARVARD
HIV REFERENCE LABORATORY

PRINCESS MARINA HOSPITAL
GABORONE, BOTSWANA * TEL 3902671 EXT2126

BHP142

HR96

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

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 5ml

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 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

HR96

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**

hh : mm SST 5ml

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

HR96

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

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

HR96

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

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 technician

Stamp OR Initials of lab technician

Results section

LAB USE ONLY:
LID BARCODE

BOTSWANA HARVARD
HIV REFERENCE LABORATORY

PRINCESS MARINA HOSPITAL
GABORONE, BOTSWANA * TEL 3902671 EXT2126

BHP142

HR96

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

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)

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

_____

Stamp OR Initials of validating technichian

Stamp OR Initials of lab technichian