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*

**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

**BHP142**

# 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

**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

## *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**

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**

# 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 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

## *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

**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**

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

**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 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** **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)**

**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

**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** **Tube type**

hh : mm 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**

# 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**

# 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** **Tube type**

hh : mm 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

## *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

**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*

**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

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** 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

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*

**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

## *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

**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*

**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

## *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

**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** 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

## *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