

## Dengue Specimen Laboratory Submission Form



Government of Guam  
Department of Public Health & Social Services  
123 Chalan Kareta  
Mangilao, Guam 96923



**GPLH ACCESSION NUMBER**

**DATE RECEIVED**

**USED FOR DENGUE SPECIMENS  
DETECTION AND SERO-TYPING**

**PLEASE NOTE THAT ALL SECTIONS ARE TO BE COMPLETED**

**PATIENT IDENTIFICATION**

NAME AND ADDRESS OF PHYSICIAN/SCHOOL/FACILITY

LAST NAME                      MIDDLE INITIAL                      FIRST NAME

ADDRESS

LABORATORY PERFORMING DENGUE RAPID TESTING

VILLAGE                                      ETHNICITY

CLINICAL DIAGNOSIS

TELEPHONE NO                                      OCCUPATION

CATEGORY OF AGENT SUSPECTED

STATUS	DATE OF BIRTH	SEX
<input type="checkbox"/> Guam Resident	___ / ___ / ___	<input type="checkbox"/> Male
<input type="checkbox"/> Tourist	RACE	<input type="checkbox"/> Female

LABORATORY EXAMINATION REQUESTED

HOSPITALIZATION REQUIRED?	HOSPITAL ADMIT DATE: ___ / ___ / ___
<input type="checkbox"/> Yes <input type="checkbox"/> No	

SPECIFIC AGENT SUSPECTED

**DATE OF ONSET:** \_\_\_ / \_\_\_ / \_\_\_

CHART NUMBER:

**SPECIMEN INFORMATION**

**SEROLOGY SPECIMEN**

- ACUTE SPECIMEN
- CONVALESCENT SPECIMEN

**DATE OF COLLECTION**  
\_\_\_ / \_\_\_ / \_\_\_

**RAPID SCREEN TESTING**                       DONE                       NOT DONE  
**DATE OF TESTING** \_\_\_ / \_\_\_ / \_\_\_

**RAPID TEST KIT USED: (PLEASE INDICATE)**  
 POSITIVE                                       NEGATIVE

**DO NOT WRITE BELOW THIS LINE. DEPARTMENT OF PUBLIC HEALTH USE ONLY**

- |          |                                   |                                   |
|----------|-----------------------------------|-----------------------------------|
| DENGUE 1 | <input type="checkbox"/> POSITIVE | <input type="checkbox"/> NEGATIVE |
| DENGUE 2 | <input type="checkbox"/> POSITIVE | <input type="checkbox"/> NEGATIVE |
| DENGUE 3 | <input type="checkbox"/> POSITIVE | <input type="checkbox"/> NEGATIVE |
| DENGUE 4 | <input type="checkbox"/> POSITIVE | <input type="checkbox"/> NEGATIVE |

SPECIMEN REFERENCE NUMBER: \_\_\_\_\_  
DATE REPORTED \_\_\_ / \_\_\_ / \_\_\_    TECH INITIALS: \_\_\_\_\_

**COMMENTS:**

**1. CLINICAL SIGNS AND SYMPTOMS**

- FEVER (Maximum Temperature) \_\_\_\_\_ °C / °F
- HEADACHE                                       RASH
- RETRO-ORBITAL EYE PAIN                       MILD BLEEDING
- JOINT PAIN    MANIFESTATION (NOSE OR GUM
- LOW WHITE CELL COUNT                       VOMITING
- MUSCLE PAIN     THROMBOCYTOPENIA
- BONE PAIN     ABDOMINAL PAIN

**2. MEDICAL CONDITION**

- DIABETES                                       HIV INFECTION
- ASTHMA     PREGNANCY
- EMPYSEMA                                       OBESITY (BMI) \_\_\_\_\_
- HEART DISEASE                                       OTHER \_\_\_\_\_
- IMMUNE SUPPRESSION

**3. LIST ANY TRAVELING WITHIN THE 7 DAY PERIOD PRIOR TO ONSET OF ILLNESS (Places & Dates)**

**4. PATIENT EVER RECEIVED DENGUE VACCINE?**

YES                                       NO

**DATE OF LAST VACCINATION :** \_\_\_ / \_\_\_ / \_\_\_