

# 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

NAME AND ADDRESS OF PHYSICIAN/SCHOOL/FACILITY

PATIENT IDENTIFICATION

LAST NAME MIDDLE INITIAL FIRST NAME

ADDRESS

LABORATORY PERFORMING DENGUE RAPID TESTING

VILLAGE

ETHNICITY

CLINICAL DIAGNOSIS

TELEPHONE NO

OCCUPATION

CATEGORY OF AGENT SUSPECTED

STATUS

☐ Guam Resident

☐ Tourist

DATE OF BIRTH

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

SEX

☐ Male

☐ Female

LABORATORY EXAMINATION REQUESTED

RACE

HOSPITALIZATION REQUIRED?

☐ Yes ☐ No

HOSPITAL ADMIT

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

SPECIFIC AGENT SUSPECTED

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

CHART NUMBER:

## SPECIMEN INFORMATION

SEROLOGY SPECIMEN

DATE OF COLLECTION

☐ ACUTE SPECIMEN

☐ CONVALESCENT SPECIMEN

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

RAPID SCREEN TESTING

☐ DONE

☐ NOT DONE

DATE OF TESTING \_\_\_\_ / \_\_\_\_ / \_\_\_\_

RAPID TEST KIT USED: (PLEASE INDICATE)

☐ POSITIVE

☐ NEGATIVE

1. CLINICAL SIGNS AND SYMPTOMS

☐ FEVER (Maximum Temperature) \_\_\_\_ °C / °F

☐ HEADACHE

☐ RASH

☐ RETRO-ORBITAL EYE PAIN

☐ MILD BLEEDING

☐ JOINT PAIN

MANIFESTATION (NOSE

☐ LOW WHITE CELL COUNT

OR GUM

☐ MUSCLE PAIN

☐ VOMITING

☐ BONE PAIN

☐ THROMBOCYTOPENIA

☐ 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 : \_\_\_\_ / \_\_\_\_ / \_\_\_\_

SPECIMEN REFERENCE NUMBER: \_\_\_\_\_

DATE REPORTED \_\_\_\_ / \_\_\_\_ / \_\_\_\_ TECH INITIALS: \_\_\_\_\_

COMMENTS: