

MERS-CoV

'Lampiran 10'

VIROLOGY UNIT OF REFERRAL LAB (IMR / MKAK)		FOR LAB USE	
		LAB NO. _____	
LAB REQUEST FORM FOR MERS-CoV INVESTIGATIONS			
HOSPITAL/CLINIC _____			
1. Name:		2. Reg. No:	
3. NRIC:		4. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
5. Age:	6. Race:	7. Occupation:	
8. Marital Status:		10. Type of specimen:	
9. Clinical Findings:		<input type="checkbox"/> Throat gargle <input type="checkbox"/> Throat swab <input type="checkbox"/> Nasopharyngeal Asp/wash <input type="checkbox"/> Nasal swab <input type="checkbox"/> Sputum <input type="checkbox"/> Blood <input type="checkbox"/> Serum <input type="checkbox"/> Urine <input type="checkbox"/> Faeces <input type="checkbox"/> Others: _____	
* Symptoms:			
<input type="checkbox"/> Cough	date of onset (dd/mm/yr)		
<input type="checkbox"/> Shortness of breath	_____		
<input type="checkbox"/> Difficulty in breathing	_____		
<input type="checkbox"/> Hypoxia	_____		
<input type="checkbox"/> Fever	_____		
<input type="checkbox"/> Runny nose	_____		
<input type="checkbox"/> Acute respiratory distress syndrome	_____		
* Travel History:			
<input type="checkbox"/> Yes	If yes please state the country (s)/ province: _____	White blood cell	
<input type="checkbox"/> No	Date of visit _____ to _____	Platelet	
* Contact with confirmed MERS-CoV case		_____	
Y N <input type="checkbox"/> <input type="checkbox"/>		Chest x-ray	
Relation: _____		_____	
* Signs:		_____	
Temperature: _____		Lungs: _____	