PRIMARY SPECIMEN COLLECTION MANUAL

of

Department of Microbiology,
at
L.T.M Medical College
&
General Hospital

Version No.: 06
Issue No.: 01
Issue Date: 01/1/2018
Copy No.:
Holder’s Name:
Patient’s Name: ____________________________ Date: ____________________

IPD/OPD No.: ____________________________ Lab. No.: ____________________

Age: ____________________________ Gender: Male/Female Time of Collection: _____________ AM/PM

Ward/OPD: ____________________________ Unit: ____________________________ Time of Acceptance: ____________ AM/PM

NATURE OF SAMPLE: ____________________________ SITE: ____________________________

Clinical diagnosis: ____________________________

Signs of septicaemia: Yes / No

Whether on antibiotic/s (specify name and duration) ____________________________

Investigation required: Please tick the relevant investigation. (TICK ANY ONE)

<table>
<thead>
<tr>
<th>BACTERIOLOGY</th>
<th>MYCOBACTERIOLOGY</th>
<th>SEROLOGY</th>
<th>IMMUNOLOGY</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Aerobic smear, culture and sensitivity</td>
<td>□ Anaerobic smear and culture</td>
<td>□ VDRL</td>
<td>□ Widal</td>
</tr>
<tr>
<td>□ AFB smear</td>
<td>□ AFB culture</td>
<td>□ RA</td>
<td>□ ASO</td>
</tr>
<tr>
<td>□ Anti HBs Ab</td>
<td>□ Anti HAV IgM</td>
<td>□ Malaria Antigen</td>
<td>□ Dengue NS1 Ag Rapid</td>
</tr>
<tr>
<td>□ Anti HCV Ab</td>
<td>□ Anti HEV IgM</td>
<td>□ Leptospira Ab Rapid</td>
<td>□ Dengue NS1 ELISA</td>
</tr>
<tr>
<td>□ Anti HBs Ab</td>
<td>□ Anti HEV IgM</td>
<td>□ Leptospira IgM ELISA</td>
<td>□ Dengue Ab Rapid</td>
</tr>
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<td>□ Dengue IgM ELISA</td>
</tr>
<tr>
<td>□ Leptospira IgM ELISA</td>
<td>□ Dengue IgM ELISA</td>
<td>□ Chikungunya IgM ELISA</td>
<td></td>
</tr>
</tbody>
</table>

□ FUNGAL CULTURE

□ PARASITOLOGY

Any other ____________________________ Sign.

N.B. Separate form has to be filled, if more than one type of investigation is required.
Kindly note separate HIV Requisition form has to be filled for HIV testing.
Date of Reporting:

Direct Examination:

Cultural characteristics:

Biochemical tests:

Identification:

Antibiotic Susceptibility test:

Microbiologist

Section In-charge
**MUNICIPAL CORPORATION OF GREATER MUMBAI**  
**LOKMANYA TILAK MUNICIPAL MEDICAL COLLEGE & GENERAL HOSPITAL, SION, MUMBAI 22**  
**DEPARTMENT OF MICROBIOLOGY**  
**HIV Requisition form**

| Patient’s Name | ______________________________ |
| Lab No. | ______________________________ |
| Date | ______________________________ |
| IPD/OPD No. | ______________________________ |
| Lab No. | ______________________________ |
| Age | ______________________________ |
| Gender | Male/Female |
| Time of Collection | _______AM/PM |
| Ward/OPD. | ______________________________ |
| Unit | ______________________________ |
| Time of Acceptance | _______AM/PM |

**Investigations:** 1) HIV 1 and 2 antibodies

**Exposure Categories**
1) Sexual  
2) Perinatal transmission  
3) Accidental injury  
4) Intravenous drug abuser  
5) Invasive procedure  
6) Blood / Blood products

**Constitutional symptoms**
1) Fever > 1 month  
2) Cough > 2 weeks  
3) Diarrhoea > 1 month  
4) Weight loss > 10%  
5) Malaise > 1 month  
6) Others

**Presence of STI**  
Yes/No

**Opportunistic infection**
1) Pulmonary TB  
2) Extra Pulmonary TB- (Specify)  
3) Candidiasis  
4) Cryptococcosis (Specify)  
5) Others

**Other Indications for test** (Specify)

**Signature of Clinician**

**Date:**

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**Note:** Sample for HIV test will not be accepted unless this form is duly filled and signed by both the patient and clinician.

**Consent form for HIV testing/ एचआइवी चेक चेक**

This is to state that I have been counseled about the HIV test and have been explained about the implications of the test results. All the details pertaining to HIV, its transmission, prevention; testing procedures and its limitations and the interpretations of the results have been explained to me in a manner that I can understand.

I hereby, given my consent for the test to be conducted on me in order to ascertain my HIV serostatus.

**Signature of client/ अशिषाधी स्वास्थी:** ______________________________  
**Date:** ______________________________

**Name of client/ अशिषाधी नाव:** ______________________________________________________________________________________

**Counseled by Name:** ______________________________  
**Signature:** ______________________________
Note:-

1) Consent obtained for carrying out procedure in hospitals does not include consent for HIV testing. Separate consent has to be taken for an HIV test.
2) Informed consent of parents/guardians is required prior to testing of minors for HIV.
3) Informed consent can be given by persons suffering from mental illness depending upon their current conditions as assessed by the designated authority; else, consent of their guardians should be obtained prior to HIV testing (Referral to trained mental health professionals should be made if required).
4) In case of unconscious patients, where HIV test is in the best interest of the patients for HIV management, Consent should be taken from one of the following: parents, spouse or closest relative or, in cases of non-availability, the HIV test may be carried out on recommendations of two attending medical practitioners.
5) Non-Voluntary disclosure of confidential medical information including HIV status may be made in cases where such disclosure is medically beneficial for the client or in cases where there is risk of HIV transmission to an identifiable partner. The disclosure can be made to a health care worker who is directly involved in the case or treatment of the client. The disclosure can also be made if there is threat to the life of the client (suicidal intention) or his/her partner or spouse (partner notification).

टिपः

१. समागमात विवेश याचणण / तपासण्या करण्यासाठी घेण्याचा आणण्या सर्वसाधारण संभवती म्हणून एक आधा द्वी संबंधी घ्याची व समावेश नसला. एक आधा द्वी चारणीसाठी वेगळे संभवती घेण्यासाठी.
२. अज्ञात व्यक्तीच्या संघर्षातील याचणणसंबंधीच्या आवश्यक संभवती अशा व्यक्तीमध्ये / बालकाच्या पालकांकडून पेटली जावी
३. मानसिक आपदादायी असलेल्या व्यक्तीकडून , त्याच्या संज्ञेच्या स्पष्टीकरणात नेमून त्याच्या अधिकारी नीलेल्या माहितीच्या आधारावर एक आधा द्वी चारणीसाठी संभवती घेण्यासाठी अथवा अशा व्यक्तीच्या काही दा प्राप्तीतील स्वीकारलेल्या व्यक्तीकडून एक आधा द्वी चारणी करण्यापूर्ती संभवती घेण्यासाठी.
४. बेशुद्धार्थीस्थीतील रुग्णाच्या बाबतीत उपचाराचा रुझीने एक आधा द्वी संगण्याचे निदान करण्यासाठी आवश्यकता असल्यास व संबंधीची स्पष्टीकरण संभवती रुग्णाचे पालक , पती / पत्नी , जवळपासना नातेवाळपासनांचं यांचंपकी , जो त्याच्या उपलब्ध असेल त्याच्या उपचारकडून घेण्यासाठी. रुग्णाच्या नातेवाळकपी कौनसीही उपलब्ध नसल्यास आणि अज्ञातासाठी अशी चारणी आवश्यकता असल्यास , रुग्णाच्या उपचार करण्यास दोन डोक्टरांची याबाबती शिक्षास / अनुभवाचं देऊनच हे चारणी करण्यासाठी
५. जर रुग्णास वेदुत्कीर्ती हेच्या फार्मेशन ठरत असेल तर एक आधा द्वी संगण्याची स्पष्टीकरण ह्या इतर गोपनीय वेदुत्कीर्ती माहिती (NON VOLUNTARY) उपचार करत येऊ शकते किंवा रुग्णाच्या अज्ञातासाठी शेणाच्या सामाजिक असर (Identifiable Partner) रुग्णांकडून एक आधा द्वी संगण्याचा संभाव्य घोषक असल्यास पण अशी गोपनीय माहिती रुग्णाच्या जीवाना (आतापर्यंत विवाचारांचा ) किंवा त्याचा / लिंच्या सामीताचा / पती / पत्नीच्या जीवाना धोका निरीक्षण होत असेल तर ही माहिती उघड करण्यास येऊ शकते (Partner Notification)
Mumbai Jalhe Andh Niyamgri Sanshodh

Mumbai, L.T.M. Medical College & General Hospital

Name of the Laboratory: Department of Microbiology, L.T.M. Medical College & General Hospital, Mumbai 22

Document No: LTMMCGH/Level 3/Form 1A/ANC Requisition Form & Consent

Controlled Copy
CONSENT FORM

Name of the Child: ___________________________

Name of the Parent / Guardian: ___________________________

Date of Birth: ___________________________

Age: ________ Months

I have been informed that the HIV DNA PCR rapid RT-PCR test will be conducted on the child and that the result will be indicative of the presence of HIV DNA and hence HIV infection. The results have been explained to me in a manner that I can understand.

I hereby give my consent for the child to undergo the above HIV DNA PCR rapid RT-PCR test.

Note:
1. Denotative and/or suggestive results of HIV status will be evaluated after review by expert HIV clinicians.
2. The patient's sample will be collected from the child's oral swab or blood sample and tested for HIV DNA. If positive result is obtained, the child will undergo further testing for a confirmatory diagnosis.
3. Written informed consent is mandatory for testing HIV status in children.
4. The results will be shared with the designated person.

Date: ___________________________

Signature: ___________________________
**Department of Microbiology**

**Form No 1C : CD4 Requisition**

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**Mycrobiology Department**

College Building, 4th Floor, R. No. 401

**Name of ART Centre:** LTMGH, Sion

**Requisition Form for CD4 Count**

**Patient's Name:**

**Age:**

**Sex:**

**Registration No.:**

**Doctor In-charge ART/MO:**

**Ward No. / OPD:**

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**CLINICAL HISTORY**

1. Weight loss > 10% of the Body Weight:
   - [ ] No
   - [ ] Yes
2. Diarrhoea:
   - [ ] No
   - [ ] Yes
3. Herpes Zoster:
   - [ ] No
   - [ ] Yes
4. Candidiasis: Oral / Oesophageal / others
   - [ ] No
   - [ ] Yes
5. Pulmonary TB:
   - [ ] No
   - [ ] Yes
6. Extra-pulmonary TB (incl. disseminated):
   - [ ] No
   - [ ] Yes
7. Pneumonia (PCP):
   - [ ] No
   - [ ] Yes
8. Meningitis (Crypto):
   - [ ] No
   - [ ] Yes
9. Any other opportunistic infection (Specify):
   - [ ] No
   - [ ] Yes
10. Malignancies (Specify):
    - [ ] No
    - [ ] Yes
11. ANC (pregnant woman):
    - [ ] No
    - [ ] Yes
12. Clinical Diagnosis:
    - [ ] No
    - [ ] Yes
13. Antiretroviral Treatment:
    - [ ] No
    - [ ] Yes

---

**Previous CD4 / CD8 report if any**

<table>
<thead>
<tr>
<th>Date</th>
<th>Absolute CD4 Count</th>
<th>CD4 %</th>
<th>Absolute CD8 Count</th>
<th>CD8 %</th>
<th>CD4 / CD8 Ratio</th>
<th>Absolute Lymphocyte Count</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**To be filled in by Microbiology Department:**

**Lab. No.:**

**Present CD4 Report:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Absolute CD4 Count</th>
<th>CD4 %</th>
<th>Absolute CD8 Count</th>
<th>CD8 %</th>
<th>CD4 / CD8 Ratio</th>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Name of Microbiology Officer:**

**Stamp:**

LTMG Sion,
MOP Nu, Maharashatra

---

**Name of the Laboratory:** Department of Microbiology, L.T.M. Medical College & General Hospital, Mumbai 22

**Document No:** LTMMCGH / Level 3 / Form 1C / CD4 Requisition form EID Card & Consent

**Controlled Copy**
Name of the Laboratory: Department of Microbiology, L.T.M. Medical College & General Hospital, Mumbai 22

Document No: LTMMCGH / Level 3 / Form 1B / EID Card & Consent

Controlled Copy
Lokmanya Tilak Municipal Medical College and General Hospital

Department of Microbiology

Sample Rejection form

No:

Name of the patient: _______________________________________________________________

Registration No.: ____________       Ref. by: _______________

Date and time sample received: ___________________

Test requested: __________________________________

Date and time sample rejected: ____________________

<table>
<thead>
<tr>
<th>Sr. No</th>
<th>Reason for rejection of sample</th>
<th>Tick the appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No requisition form / test not mentioned</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Soiled Requisition form</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Label on form and sample not matching</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>No signature / consent on the form</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Single form with multiple tests</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>No sample</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Leaking sample</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Dry Swab / inappropriate sample</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Repeat sample received on same day</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Delay in sample transport</td>
<td></td>
</tr>
</tbody>
</table>

Inappropriate sample: Lipaemic / haemolysed / QNS / Clotted (CD4 test)

Informed to: _________________________________________________________________

Corrective action suggested: ___________________________________________________

Name and initials of LT _____________________________________________

Name and sign of Technical Manager: _________________________________________