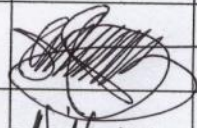
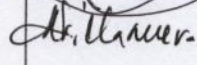



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	Document Type:	Work Instruction
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	Department/Section:	Molecular Laboratory
	Document Title:	SARS-COV-2 SAMPLE LABELING

APPROVAL:

	Name/Title	Signature	Date
Prepared by:	JESSA CHRIS B. REMOLLENO, RMT Medical Technologist/ Molecular Biology Analyst		
Verified:	DAVID G. PEDROZA, MD Associate Pathologist		5/11/2022
	MONICA B. VILLANUEVA, RN, RMT, PhD Laboratory Director		7-11-2022
	MELANIE ROSE B. ZERRUDO, MD, FPSP Chair, Department of Pathology		7-11-2022
Reviewed by:	DENNIS C. ESCALONA, MN, FPCHA, FPSQua Quality Assurance Supervisor		7-11-2022
Recommending Approval:	ROSARIO D. ABARING, MN, MBA-HA, PhD, FPCHA Ancillary Services Division Officer		
	HENRY F. ALAVAREN, MD, FPSMID, FPSQua Total Quality Division Officer		
Approved:	GENESIS GOLDI D. GOLINGAN President and CEO		

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PURPOSE:

This procedure describes optimal conditions and procedure for collection of respiratory specimen for COVID-19 testing and explains how to label a sample correctly before it is sent to the laboratory for testing.

SCOPE:


Applies to all Molecular Laboratory staff of Dr. Pablo O. Torre Memorial Hospital.

PERSON RESPONSIBLE:

Medical Technologist, Molecular Biology Laboratory Analysts

GENERAL GUIDELINES:


1. Medical Technologist assigned for sample collection must obtain labelling information and verify this information as correct with the patient before collecting the patient's specimen.
 - 1.1. Use 2 patient identifier.
 - a) Compare the information supplied by the patient with:
 - b) Information indicated on the Lab Request Form
 - c) Hospital records (if the patient is admitted to the hospital) or with the social security card or other legal identification (if the patient is not admitted).
 - 1.2. If there is concordance of the patient identifying information, the collector can proceed to specimen collection.
2. Before starting specimen collection, in the presence of the patient, label all specimen containers with indelible ink with the following information:
 - 2.1. Patient's first and last names (including maiden name if applicable);
 - 2.2. Personalized identification number (e.g. government ID, Company ID)
 - 2.3. Date of birth;
 - 2.4. Sex;

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- 2.5. Date and hour of specimen collection;
- 2.6. Type of specimen;
- 2.7. Specimen collector's name.
3. The specimens will be accepted if they meet the acceptability criteria established and detailed in the *SOP Sample Rejection or Acceptance*.
4. Problems and solutions.
 - 4.1. If the hospitalized patient has no identity number: ask the patient's nurse or responsible party to confirm the patient's identity. Never trust the information found at the end of the bed. Resolve any discordance before proceeding to specimen collection.
 - 4.2. If the patient cannot give his/her name: ask the person accompanying the patient. Resolve any discordance before proceeding to specimen collection.
 - 4.3. If the patient's information does not correspond to information written down on the Test Request Form: communicate with the person accompanying the patient and resolve any discordance before proceeding to specimen collection.

PROCEDURE:


1. Medical Technologist assigned for specimen collection receives request/ or assessment for SARS-COV-2 RT-PCR Testing.
2. Medical technologist then goes to the assigned area for sample collection. Upon arrival, the medical technologist must verify patient's data by letting the patient state his name and his birthday. In cases where, patient is unconscious, verify the patient data through the next of kin or folks available and or nurse in charge.
3. Before collection, make sure that the patient has completely filled out the Case Investigation Form.
4. Medical technologist must verify the patient's identity and that of the prescribing doctor.

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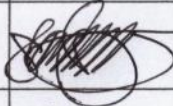
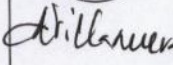


5. In cases where patient is unconscious, verify the patient's identity through the folks or next of kin if there is any, if none, verify through the nurse-in-charge.
6. Medical technologist labels the primary and secondary containers in the presence of patient.
7. Label specimen in the presence of the patient, label all specimen containers with indelible ink with the following information:
 - 7.1. Patient's first and last names (including maiden name if applicable)
 - 7.2. Personalized identification number (e.g. social security, company ID)
 - 7.3. Date of birth
 - 7.4. Sex
 - 7.5. Date and hour of specimen collection
(See Annex 3 for Sample Labelling guide.)
8. Medical technologist must write clearly and legibly.


REFERENCES:

1. <http://ritm.gov.ph/announcements/download-case-investigation-form-cif-here>
2. Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for COVID-19, <https://www.cdc.gov/coronavirus/2019-ncov/lab/guidelines-clinical-specimens.html>.
3. RITM BioRisk Managment Office, Interim Biosafety Guidelines for Handling and Testing SARS-CoV-2 (COVID-19) specimens, March 15, 2020.

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APPROVAL:

	Name/Title	Signature	Date
Prepared by:	JESSA CHRIS B. REMOLLENO, RMT Medical Technologist/ Molecular Biology Analyst		
Verified:	DAVID G. PEDROZA, MD Associate Pathologist		07/11/2022
	MONICA B. VILLANUEVA, RN, RMT, PhD Laboratory Director		7-12-2022
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Recommending Approval:	ROSARIO D. ABARING, MN, MBA-HA, PhD, FPCHA Ancillary Services Division Officer		
	HENRY F. ALAVAREN, MD, FPSMID, FPSQua Total Quality Division Officer		
Approved:	GENESIS GOLDI D. GOLINGAN President and CEO		

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ANNEX 1:

TEST REQUEST FORM

 <p>DR. PABLO O. TORRE MEMORIAL HOSPITAL Owned and Operated by Riverside Medical Center Inc. B.S. Aquino Drive, Bacolod City</p>		<p>STATION 1 / 200 OUTPATIENT DEPARTMENT</p>	
Patient Name:		Income Center:	LABORATORY
Admission No.:		Transaction No.:	
Company/HMO:		Document No.:	CH
Hospital No.:		Reference Date:	
Age / Gender / BDate:		Patient ID:	
Attending Physician:		Track No.:	



Items Description	Qty.	Price	Amount	Remarks
COVID-19 RT- PCR	1.00	6,000.00	6000.00	

Remarks:	Total>>>	6,000.00
Requested By:	Discount>>>	0.00
Request Time / Date:	Net Amount>>>	
Rendered By:		
Rendered Time / Date:		


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ANNEX 2:

CASE INVESTIGATION FORM

 <p>Philippine Integrated Disease Surveillance and Response</p>			
Case Investigation Form Coronavirus Disease (COVID-19)			
*Required *On-site Reporting Unit/Hospital: RESEARCH INSTITUTE FOR TROPICAL MEDICINE		*Name of Investigator: _____ *Date of interview: (mm/dd/yyyy) _____	
1. Patient Profile			
*Last Name: _____	*First Name: _____	*Middle Name: _____	*Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
*Occupation: _____	*Civil Status: _____	*Nationality: _____	*Passport No.: _____
2. Philippine Residence			
2.1 Permanent Address			
*House No./Building/Street/Subd./Purok: _____	*Barangay: _____	*Municipality/City: _____	*Province: _____
*Region: _____	*Home Phone No.: _____	*Cellphone No.: _____	*Email address: _____
2.2 Current Address			
*House No./Building/Street/Subd./Purok: _____	*Barangay: _____	*Municipality/City: _____	*Province: _____
*Region: _____	*Home Phone No.: _____	*Work Phone No.: _____	*Other Email address: _____
3. Address Outside the Philippines (for Overseas Filipino Workers and individuals with Residence Outside the Philippines)			
Employer's Name: _____	Occupation: _____	Place of Work: _____	
House No./Bldg. Name: _____	Street: _____	City/Municipality: _____	Province: _____
Country: _____	Office Phone No.: _____	Cellphone No.: _____	
4. Travel History			
History of travel/travelwork in other countries with a known COVID-19 transmission 14 days before the onset of your signs and symptoms: <input type="checkbox"/> Yes <input type="checkbox"/> No		Port/Country of exit: _____	
Airline/Sea vessel: _____	Flight/Vessel Number: _____	Date of Departure: (mm/dd/yyyy) _____	Date of Arrival in Philippines: _____
5. Exposure History			
History of Exposure to Known COVID-19 Case 14 days before the onset of signs and symptoms: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If yes: Date of Contact with Known COVID-19 Case: (mm/dd/yyyy) _____	
Have you been in a place with a known COVID-19 transmission 14 days before the onset of signs and symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If yes: Place: <input type="checkbox"/> Workplace <input type="checkbox"/> Mouth facility <input type="checkbox"/> Social gathering <input type="checkbox"/> Religious gathering <input type="checkbox"/> Others, specify type: _____ Date when you have been in that place (mm/dd/yyyy): _____ Name of the place: _____	
List the names of persons who were with you during the (these) occasion(s) and their contact numbers. Use the back part of this sheet when needed.		Name: _____ Contact number: _____ _____ _____	
6. Clinical Information			
Disposition at Time of Report: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Discharged <input type="checkbox"/> Died <input type="checkbox"/> Unknown		Date of Onset of Illness (mm/dd/yyyy): _____	
Date of Admission/Consultation (mm/dd/yyyy): _____		Fever: _____°C <input type="checkbox"/> Cough <input type="checkbox"/> Sore throat <input type="checkbox"/> Colds <input type="checkbox"/> Shortness/difficulty of breathing	
Other signs/symptoms, specify: _____		Is there any history of other illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If YES, specify: _____		Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Chest X-ray done? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, when? (mm/dd/yyyy) _____	
CXR Results: Pneumonia: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending		LMP: (mm/dd/yyyy) _____ Assessed as High Risk? <input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Specimen Information			
Specimen Collected: _____	IFYES Date Collected (mm/dd/yyyy): _____	Date sent to RITM (mm/dd/yyyy): _____	Date received in RITM (to be filled up by RITM): _____
<input type="checkbox"/> Serum	<input type="checkbox"/> Oropharyngeal	<input type="checkbox"/> Nasopharyngeal swab	<input type="checkbox"/> Other: _____
Virus Isolation Result: _____		PCR Result: _____	
8. Classification			
<input type="checkbox"/> Suspect Case		<input type="checkbox"/> Probable Case	
<input type="checkbox"/> Confirmed Case			
9. Outcome			
Date of Discharge: (mm/dd/yyyy): _____		Condition on Discharge: <input type="checkbox"/> Improved <input type="checkbox"/> Recovered <input type="checkbox"/> Transferred <input type="checkbox"/> Absconded <input type="checkbox"/> Died	
Name of Informant: (if patient not available): _____		Relationship: _____ Phone No.: _____	

COVID-19 CIF for Regular Patient / Referred Patient | RITM version 2 | Updated 30 September 2020

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ANNEX 3

SAMPLE LABELLING

Medical Technologist assigned for specimen collection receives request/ or assessment for SARS-COV-2 RT-PCR Testing. (See Annex 1)

DR. PABLO O. TORRE MEMORIAL HOSPITAL
Owned and Operated by Riverside Medical Center Inc.
B.S. Aquino Drive, Bacolod City

STATION 1 / 200
OUTPATIENT DEPARTMENT
Income Center: LABORATORY
Transaction No.:
Document No.: CH
Reference Date:
Patient ID:
Track No.:

Patient Name:	
Admission No.:	
Company/HMO:	
Hospital No.:	
Age / Gender / SDate:	
Attending Physician:	

Items Description	Qty.	Price	Amount	Remarks
COVID-19 RT-PCR	1.00	6,000.00	6000.00	
			Total>>>	6,000.00
			Discount>>>	0.00
			Net Amount>>>	

Remarks:
Requested By:
Request Time / Date:
Rendered By:
Rendered Time / Date:


Before collection, make sure that the patient have completely filled out the Case Investigation Form. (See Annex 2)





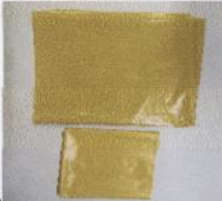

Prepare materials Needed:

1. UTM/VTM & Polyester swab
2. Marker & Sticker for labeling
3. Para film


1.


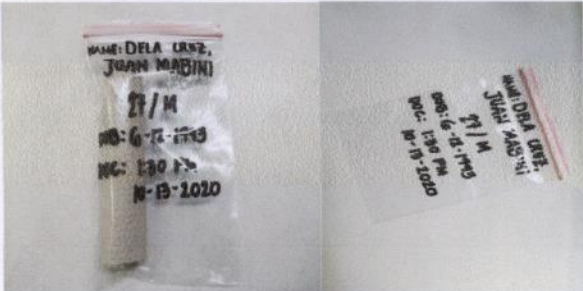
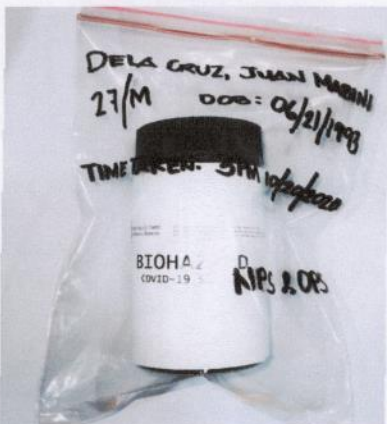
2.

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<p>4. White & Brown Colored Interfolded Tissue Paper</p> <p>5. Small Ziplock</p> <p>6. Screw Cap Container</p> <p>7. Yellow Plastic Bag</p> <p>8. Transport Box</p>	<p>3.</p> 	<p>4.</p> 
	<p>5.</p> 	<p>6.</p> 
	<p>7.</p> 	<p>8.</p> 

Label VTM with Patient's first and last	
---	--

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name (including maiden name if applicable), Date of birth, Age, Sex, Date and hour of specimen collection	
Label zip lock with Patient's first and last name (including maiden name if applicable), Date of birth, Age, Sex, Date and hour of specimen collection.	
Store sample in a triple package. After storing VTM in zip lock, store it in a screw cap container and Store in a Bigger Zip lock with the label of Patient's first and last name (including maiden name if applicable), Date of birth, Age, Sex, Date and hour of specimen collection and type of specimen. Store in refrigerator at 2-8°C. Sample must be sent to Molecular Biology Laboratory for Testing.	

Place sample inside the transport box and	
---	--

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send to Molecular Biology Laboratory for
Testing with the required documents.

Documents to accompany:

- *Linelist*
- *Case Investigation Forms*
- *Referral Forms*
- *Photocopy of Patient's ID*



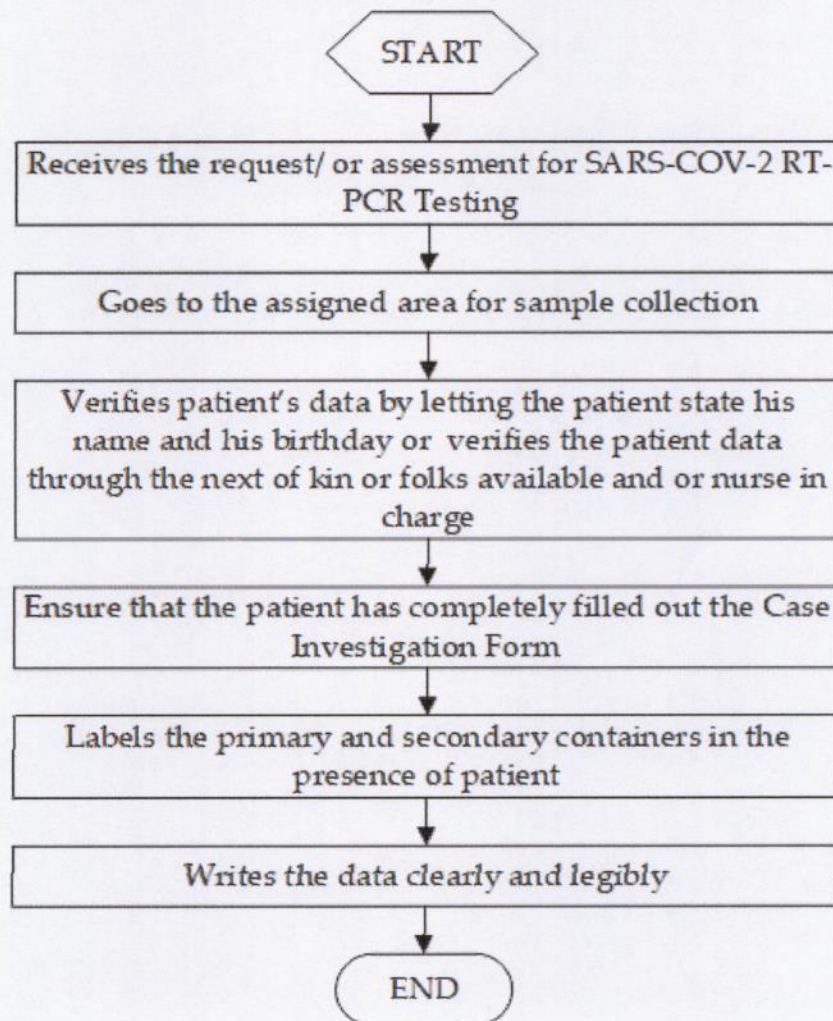



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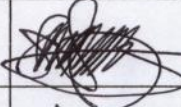
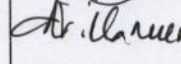
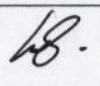

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FLOWCHART



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	Name/Title	Signature	Date
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KEY TASKS	PERSON RESPONSIBLE
1. Receives the request/ or assessment for SARS-COV-2 RT-PCR Testing	Medical Technologist
2. Goes to the assigned area for sample collection	
3. Verifies patient's data by letting the patient state his name and his birthday or verifies the patient data through the next of kin or folks available and or nurse in charge	
4. Ensure that the patient has completely filled out the Case Investigation Form	
5. Labels the primary and secondary containers in the presence of patient	
6. Writes the data clearly and legibly	