

GOVERNMENT ANALYST DIVISION
MINISTRY OF HEALTH AND WELLNESS
1ST FLOOR, NATIONAL LABORATORIES COMPLEX
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GAD/DI/087
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REQUEST FORM FOR TOXICOLOGY/BLOOD ALCOHOL/CHOLINESTERASE/TRACE METAL ANALYSIS

*(This form shall be used for **non-police cases only** and kindly read Instructions at Section 7 before filling)*

1. PATIENT INFORMATION (TO BE FILLED BY OFFICER FROM HOSPITAL/MEDICAL INSTITUTION/INDIVIDUAL)

Patient's Surname :

Other Name(s)[†] :

Gender : M ☐ F ☐ Age (Y) :

Hospital/ Medical Institution[†] :

Ward : Card No. :

History of Case :

Date/Time Poison was ingested :

Treatment given prior to sample collection :

**OFFICIAL
STAMP[†]**

2. SAMPLE INFORMATION

Nature of Sample submitted (Tick ✓ as appropriate)	To be submitted in	Date/time of Collection	Quantity submitted (Volume/Weight per Tube/Container)	Laboratory Sample Reference No. (For Laboratory)
<input type="checkbox"/> Stomach Washout	Plain tube/Container mL/...../...../.....
<input type="checkbox"/> Urine	Plain tube/Container mL/...../...../.....
<input type="checkbox"/> Whole Blood	EDTA/Heparin tube (For Toxicology, Cholinesterase and Trace metal) Oxalate tube (For Ethyl Alcohol) mL/...../...../.....
<input type="checkbox"/> Clotted Blood	Plain tube mL/...../...../.....
<input type="checkbox"/> Remains of suspected cause of poisoning	Plain tube/Container mL/g/...../...../.....
<input type="checkbox"/> Others (Specify): mL/g/...../...../.....

3. ANALYSIS REQUESTED

☐ Toxicology/ Ethyl Alcohol Level /Cholinesterase Level ☐ Blood Ethyl Alcohol Level only ☐ Cholinesterase Level only

☐ Trace Metal Level only (Specify):

☐ Others (Specify):

I agree that :

(i) the information given above is true and correct,

(ii) information/data will be stored and used in accordance with the Data Protection Act and disclosure of same by you (customer) will be at your own responsibility,

(iii) information submitted above and generated will not be put in the public domain by the Government Analyst Division,

(iv) I will be informed in advance on notification of relevant authorities on issues of National/Public Health interest,

(v) a description of the handling process for complaints shall be made available to any interested parties on request, and

(vi) Non submission of mandatory information marked with † may entail non-acceptance of sample.

Requested by Medical Practitioner †

Name : Status : Signature : Date :

4. DISCLAIMER

The accreditation of the Government Analyst Division or any of its reports or certificates in no way constitute or imply product, process, service, management system or person (where relevant) approval by MAURITAS

5. CRITERIA FOR SAMPLE SUITABILITY

(FOR LABORATORY USE ONLY)

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(i) Sample accompanied with request form (GAD/DI/087)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(ii) Request form signed by Medical Practitioner	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(iii) Name and/or Original stamp of Hospital/Health Institution	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(iv) Label on sample submitted is legible	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(v) Label on sample corresponds with patient name in request form	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(vi) Test(s) requested specified	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(vii) Whole blood submitted suitable for Blood Alcohol Level/ Cholinesterase Level/ Trace Metal Level	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> NA

Sample meets suitability criteria: Yes ☐ No ☐

Remarks/Observations (if any) :

Sample Criteria verified by: Signature:

6. REVIEW OF REQUEST AND SAMPLE SUITABILITY

Review of request done with regards to Resources (Personnel – Availability and Competence, Equipment, Certified Reference Standard/ Material, Consumables), Appropriate Methods or Procedures, Turn around Time(TAT) and sample **can be accepted/ cannot be accepted**. (Delete as appropriate)

Remarks (if any):

Sample suitable for analysisSample condition upon receipt: Ambient ☐ Chilled ☐ Frozen ☐ Other:

Sample submitted by : Signature :

Sample not suitable for analysis

Reason for non-suitability:

Sample returned : ☐ Yes ☐ No ☐ Discarded Date/Time :

Sample returned to : Sample returned by :

Review of Request, Determination of Sample Suitability and Sample Receipt done by:

Name : Status : Signature : Date :

7. COMMUNICATION/RECORD OF REVIEW/PERTINENT DISCUSSION WITH MEDICAL PRACTITIONER ON DEVIATION FROM METHOD AND TEST REQUESTED AND ON ANALYSIS RESULTS BY PHONE (IF ANY)Name of Officer
(Laboratory) : Signature : Date :Name of Officer
(Hospital/Medical Institution/Individual) : Signature
(If any) : Date :**8. INSTRUCTIONS**

- (i) Information with marked with † are mandatory and shall be required for generation of Toxicological Report.
- (ii) Each tube containing sample should bear the name of the patient and properly closed to prevent spillage.
- (iii) Alcohol swab shall not be used prior to collection of blood sample for alcohol level determination.
- (iv) Unlabeled sample tubes, incomplete filling of mandatory information and request form without official hospital/Medical Institution seal/stamp may not be accepted.