आई. सी. एम. आर. – राष्ट्रीय कॉलरा और आंत्र रोग संस्थान
ICMR - NATIONAL INSTITUTE OF CHOLERA AND ENTERIC DISEASES
स्वास्थ्य अनुसंधान विभाग, स्वास्थ्य और परिवार कल्याण मंत्रालय, भारत सरकार
Department of Health Research, Ministry of Health and Family Welfare, Govt. of India
WHO COLLABORATING CENTRE FOR RESEARCH AND TRAINING ON DIARRHOEAL DISEASES

Ref: NICED/Stores/Printing/VRDL/2023-24 Date: 05.10.2023

QUOTATION ENQUIRY

Sealed quotations are invited on behalf of Director, ICMR-National Institute of Cholera & Enteric Diseases, Kolkata so as to reach this office by 12th October 2023 till 03:00 p.m. with regard to printing and preparing the below mentioned documents:

Sl. No.	Item	Description Work	Quantity
01	Case Record Form (CRF)	Paper: 80 GSM, size: A4, Both side print	15000 copies
02	Test Record Form (TRF)	Paper: 80 GSM, size: A4, Both side print	10,000 copies
03	Severe Acute Respiratory Infection form (SARI) & Treatment Form	Paper : 80 GSM, size:A4, 2 sheet both side print	5000 set (comprising of two sheet; both side print)

Interested vendors are requested to kindly visit our office premises on any working days within the below mentioned time before submitting the final quotation.. The quotation superscripted as "**QUOTATION FOR PRINTING OF PATIENT REQUISITION FORMS (CRF, TRF SARI & TREATMENT FORM) FOR VRDL, ICMR-NICED, KOLKATA**" addressed to Director, ICMR-NICED, Kolkata should be dropped at the Tender box placed at 1st Floor of NICED-I Building latest by **12th October 2023** up to **03:00 p.m.** The last date may be extended subject to requirement. The quotation received will be opened on the same day.

Kindly note that all the above mentioned items to be supplied have to be mentioned quality. This is a **comprehensive tender enquiry** and no extra cost would be borne by ICMR-NICED after the issue of Work Order if the work is found unsatisfactory.

Terms and Conditions:

1. The Director, ICMR-NICED reserves the right to accept or reject the quotations without assigning any reasons thereof.
2. Any decision taken by the Director, ICMR-NICED at any point of time in connection with this process shall be final and conclusive and no claim or dispute from any query in this regard shall be entertained.
3. No advance payment will be made. The payment will be made on rendering the services availed and satisfactory report of the end user(s).

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P-33, C.I.T. Road, Scheme - XM, Beliaghata, Kolkata - 700010, India
निदेशक/ Director : 91-33-2363 3373, 2370 1176, पि.बि.एक्स / PBX : 91-33-2353 7469 / 7470, 2370 5533 / 4478 / 0448
फैक्स / Fax : 91-33-2363 2398, 2370-5066, वेब / Website : www.niced.org.in

4. No extra payment on account of transportation, handling, loading, unloading, labour charges etc. will be made. However, GST as per rules will be permissible.
5. While submitting the quotations the rate against each work and net amount to be paid, GST etc. should be specified separately.
6. ICMR-NICED, Kolkata does not bind itself to accept the lowest quote & reserves the right to accept the same in part or full.
7. Please ensure that the supply is as per requirement.

Store in-Charge
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आई.सी.एम.आर.-राष्ट्रीय कॉलरा और आंत्र रोग संस्थान
I.C.M.R.-National Institute of Cholera and Enteric Diseases
पी-३३, सी.आई.टी.रोड, स्कीम-एक्स.एम, बेलियाघाटा
P-33, C.I.T. Road, Scheme-XM, Beliaghata
कोलकाता-७०००१० / Kolkata-700010

NOTE: For any clarification, you may visit our office during working hours from **Monday – Friday between 10:00 a.m. – 5:00 p.m. in Stores Section**, ICMR-NICED, P-33, C.I.T. Road, Scheme-XM, Beliaghata, Kolkata-700010 before submitting the quotation.

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ICMR - NATIONAL INSTITUTE OF CHOLERA AND ENTERIC DISEASES

DHR-ICMR Virus Research and Diagnostic Laboratory Network (Ver 3.0)

CASE RECORD FORM

Format No. : NICED/VRDL/FM-002/Ver. 1.0

A. Identification Section

Lab code	0	3	4	Year			Patient ID *(issued by VRDL)*						

1. Sample Origin

Outbreak/Disease cluster (Referred by Public Health Authorities)..... ☐ (go to page 2)

Outbreak/Disease cluster (Investigated by VRDL..... ☐ (go to page 2)

Medical College/Referral Hospital..... ☐

Date (*DD/MM/YY*) :

Outbreak : Investigation date

Medical college/Ref. Hosp. : Patient Visit date (OP / Admission Date (IP)

B. Patient Information

2. Patient name				
3. S/o D/o W/o			**4. Age in**	***For Infants*** *months* / *days*
5. Sex : *Male* ☐ *Female* ☐			**6. Contact Number :**	
7. Patient Address :	**Village/Town :**			**Taluk/Tehsil :**
	District :	**PIN Code :**	**State :**	**Rural / Urban / NK :**
8. Patient	*a. In-patient* ☐	*b. Out-patient* ☐	**9. Hospital OP/IP number :**	
10. Name of Clinician :			**11. Clinician's Contact number :**	
12. Referral Hospital name :				

C. Clinical Details (Tick all that apply)

13. Date of onset of illness (*DD/MM/YY*) : **14. Duration of illness (in days) :**

Syndromes	*Associated Symptoms*			
15. Diarrhoea ☐	*1. Fever* ☐	*2. Diarrhoea* ☐	*3. Dysentery* ☐	
	4. Pain in addomen ☐	*5. Vomiting* ☐	*6. Others (Specify)* ☐	
16. Respiratory ☐	*1. Fever* ☐	*2. Sore throat* ☐	*3. Cough* ☐	*4. Rhinorrhoea* ☐
	5. Breathlessness ☐	*6. Others (Specify)* ☐		
17. Fever of Unknown Origin ☐	*1 : Fever* ☐	*2. Any localizing symptoms* ☐		
18. Rash ☐	*1. Fever* ☐	*2. Macular* ☐	*3. Papule* ☐	
	4. Maculo-papular ☐	*5. Eschar* ☐	*6. Pustule* ☐	
	7. Bullae ☐	*8. Others (Specify)* ☐		
19. Jaundice ☐	*1. Fever* ☐	*3. Jaundice* ☐	*3. Dark urine* ☐	*4. Hepatomegaly* ☐
	5. Nausea ☐	*6. Vomiting* ☐	*7. Abdominal pain/discomfort* ☐	
20. Encephalitis/Meningitis ☐	*1. Fever* ☐	*2. Irritability* ☐	*3. Increased Somnolence* ☐	
	4. New onset of Seizures ☐	*5. Neck rigidity* ☐	*6. Altered sensorium* ☐	
	7. Change in mental status ☐	*8. Others (Specify)* ☐		
21. Haemorrhagic Fever ☐	*1. Fever* ☐	*2. Rigors* ☐	*3. Headache* ☐	
	4. Chills ☐	*5. Malaise* ☐	*6. Arthralgia* ☐	
	7. Myalgia ☐	*8. Haemorrhagic manifestations* ☐		
	9. Retro-orbital pain ☐	*10. Others (Specify)* ☐		
22. Conjunctivitis ☐	*1. Fever* ☐	*2. Redness* ☐	*3. Discharge* ☐	*4. Crusting* ☐
23. Other Syndrome ☐	*Specify*			

24. Provisional diagnosis :	**25. Investigations Requested :**

D. Epidemiological Details

26. Presence of similar case in the house	*Yes* ☐ *No* ☐
27. Presence of similar case/s in the village/locality	*Yes* ☐ *No* ☐
28. History of travel in last 10 days	*Yes* ☐ *No* ☐
	If *Yes*, place visited

Name of the person filling form :

Signature of person filling form :

Go to Section F (Details of sample collection) in Page 2

ICMR - NATIONAL INSTITUTE OF CHOLERA AND ENTERIC DISEASES
DHR-ICMR Virus Research and Diagnostic Laboratory Network (Ver 3.0)
Format No. : NICED/VRDL/FM-002/Ver. 1.0

To be filled only for Patients/samples from *Outbreak**

*(samples sent by PHC/CHC/Dist. Health authorities and Investigated by VRDL for confirmation of outbreak/disease cluster)

E. Patient Information (to be filled by VRDL)				
1. Patient name		2. S/o D/o W/o		
3. Age in completed		*For Infants*		4. Sex : *Male* ☐ *Female* ☐
5. Patient Address :	Village/Town :	Sub Centre :		PHC/CHC :
	District :	PIN Code :	State :	Rural / Urban / NK :
Contact details of the official referring the samples from outbreak :		Name :		Ph :

6. Outbreak Number *(issued by VRDL)*	7. Date of sample collection :
8. Date of Onset of symptoms :	9. Total number of patients from whom samples are collected : 10. Patient Number within the outbreak :
11. Which of the following best describe the clinical presentation? (*Tick most appropriate option*)	
a. Fever with rash (suspected measles/rubella) ☐	*b. Fever with rash, arthralgia (suspected dengue)* ☐
c. Fever with arthralgia (suspected Chikungunya) ☐	*d. Fever with respiratory symptoms (suspected influenza)* ☐
e. Fever with jaundice (suspected HAV/HEV) ☐	*f. Fever with neurological symptoms (Suspected JE)* ☐
g. Fever with haemorrhagic manifestations ☐	*h. Acute diarrhoeal disease* ☐
i. Conjunctivitis ☐	*j. Gastroenteritis (probably food borne)* ☐
k. Acute flaccid paralysis ☐	*l. Others (Specify)* ☐
12. Provisional diagnosis :	13. Investigations Requested :

ONLY FOR LABORATORY USE

F. Details of Sample Received / Collected (Tick all that apply)

Type of samples	Blood-Plasma (P)	Blood-Serum (S)	CSF (C)	NP Swab (N)	Throat swab (T)	Rectal swab (R)	Faeces (F)	Urine (U)	Others (specify) (O)
Tick (√) for the samples received									
Date of received									
Time of received									

Sample/s received/collected by (Name) :

Signature : Date :

G. Laboratory Results

Sl. No.	Virus	Date of Testing	Sample Type	Test done	Result
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					

Sample sent to higher lab for further investigations	Yes	No

Name of the Technician performing test : **Name of the lab in-charge :**

Signature of Technician performing test : **Signature of lab in-charge :**

Date :

INDIAN COUNCIL OF MEDICAL RESEARCH | NICED NATIONAL INSTITUTE OF CHOLERA AND ENTERIC DISEASES

Format No. - NICED/VRDL/FM-001/Ver. 1.0

ICMR - NATIONAL INSTITUTE OF CHOLERA & ENTERIC DISEASES
Regional Virus Reaseach and Diagnostic Laboratory (VRDL)
Contact: 033 2370 / 4478 / 0448; 2353 7469; Ext 121 / 190 Email: vrdln.niced@gmail.com
Website: http://www.niced.org.in/niced/VRDL-ICMR-NICED.htm

Site ID:_____/___ Lab ID:____/___

TEST REQUEST FORM

Name of patient (in block letters):

Age : **Sex :**

Name of guardian:

Address (in detail):

District: **PIN code:**

Contact No.:

Patient type: Out-Patient /In-patient **Ward:** **Bed No.:**

Patient registration (IPD/OPD) no.:

Name of referring clinician : **Clinician's contact no.:**

Name of referring hospital :

Date of onset of illness:

Relevant sings and sysnptoms:

History of past illness:

Exposure history:

History of travel in last 15 days:

Biochemical parameters:

Haemoglobin		Haematocrit (%)		WBC count	
Neutrophil (%)		Lymphocytes (%)		Monocytes (%)	
Eosinophil (0%)		Basophil (%)		Platelet Count	
ESR		CRP		Procalcitonin	
Serum bilirubin (Total)		Unconjugated		Conjugated	
Serum ALT		Serum AST		Serum ALP	
Serum Albumin		Albumin/globulin ratio		Gamma glutamyl transpeptidase (GGT)	
PT		APTT		INR	
Serum Urea		Serum Creatinine			
Others					

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Serological investigations:

Chest X-ray findings:

USG findings:

CT scan/MRI findings:

Immunization history:

Whether known to be pregnant: Yes ☐ / No ☐ Gestation period:

Co-morbidity (if any):

Category which the patient belongs to (for suspected Influenza): B(i) ☐ / B(ii). ☐ / C ☐

Provisional diagnosis:

Investigations requested:

Type of specimen:

Date of specimen collection: **Time of specimen collection:**

Name of person collection the specimen:

Name of person filling the form:

Email ID of concerned hospital/clinician:

Signature & Seal

- Specimen receiving counter: **ICMR-NICED Virus Laboratory,GB4,1st Floor, ID&BG Hospital,** Beliaghata.
- Specimen receiving time: **Monday - Saturday (10.30 am to 05.00 pm)**
- The patient party will be communicated about the day of generation of report at the time of receiving specimen.
- Requests for investigations (other than influenza A H1N1) from private hospital/clinician should be forwared via IDSP / State Health Department.
- Diagnostic report of Influenza A H1N1 will be communicated only via email to the concerned hospital/clinician and state Health Department within 2 working days. No printed report will provided to the patient party.
- Refer to the website for detailed information regarding investigation performed at Regional VRDL, ICMR-NICED.

Annexure-II

SARI (IPD) CASE PROFORMA

Tick (√) in the appropriate box

Admitted patient (IPD)

	General Medicine		Pediatrics
	Respiratory Medicine		ICU
	Geriatric Medicine		Other

Date of Onset of Symptoms	D D M M - Y Y Y Y
Date of Sample Collection	D D M M - Y Y Y Y
Study ID:	**Name of Health Facility:**
Patient Reg Number:	**Patient Name:**
Contact number:	**Gender** ☐ **Male** **Female**
Age: ☐ **Year** ☐ **Month**	Birth date if known D D M M Y Y Y Y
Specimen ☐ Nasal Swab ☐ Throat swab ☐ Nasopharyngeal swab ☐ Other	
Informant ☐ Self ☐ Caregiver	
Complete address: Village/Town/City:	District: .....
..... ☐ Rural ..... ☐ Urban	
Height (cm): ..... Weight (kg):	
Pregnancy: ☐ Yes ☐ No ..... if Yes, Gestational age in months: ☐	
For children under 5 year Mid arm circumference (cm):	

Exposure History	Yes	No
Similar illness in family/neighbor		
Exposure to poultry/dead bird		
No. of family members sleeping in same room		

Exposure History	Yes	No
Smoking (self)/ Smoker in family		
Exposure to farm animals		
H/o travel abroad in past 14 days prior to onset		

Symptoms	Yes	No	Symptoms	Yes	No
Fever/History of fever (< 7 days)			Chills		
Rigors			Cough		
Sputum Production			Haemoptysis		
Sore throat			Nasal Discharge/stuffiness		
Ear ache/ discharge			Headache		
Body-ache			Malaise/Fatigue		
Chest Pain			Abdominal pain		
Vomiting/nausea			Diarrhea		
Breathlessness/ difficulty breathing			Seizures		
Other Symptoms:					
For Children Under 5 Years					
Decreased feeding			Lethargy/unconscious		

Vaccination History	Yes	No	Treatment History	Yes	No
H/o influenza vaccination within last 1yr			Antivirals (Tamiflu) in past 2 weeks		

COVID-19 Vaccination						
First Dose: Covaxin / Covishield / Sputnik V (Date)						
Second Dose: Covaxin / Covishield / Sputnik V (Date)						

Clinical Signs	Enter Value			Clinical Signs	Enter Value	
Respiratory rate/minute:				Pulse rate/minute:		
O_2 saturation (%):				Axillary temperature (°C):		
BP systolic: BP diastolic:						
	Yes	No			Yes	No
Wheeze				Nasal flaring		
Stridor in calm patient				Crepitation		
Lower chest in-drawing				Grunting		
Apnea				Accessory muscles use for breathing		
Other						

Medical History	Yes	No	Not known		Medical History	Yes	No	Not known
Chronic lung disease (COPD/Bronchitis)					Asthma			
Tuberculosis					Heart Diseases			
Diabetes					Chronic liver disease			
Chronic renal disease					Chronic neurological disease			
Hematologic disorders e.g. Thalassemia					Malignancy /Cancer			
Immunocompromised state/ steroid therapy					HIV			
Chronic diarrhea in children under 5 years					H/o influenza vaccination within last 1year			
Hypertension								
Other (specify):								

Treatment	Yes	No		Treatment	Yes	No
Antibiotics				Antivirals (Tamiflu/ Zanamavir/ Peramivir) in past 2 weeks		
Oxygen				Steroid		
Mechanical ventilation (intubation)				Bronchodilators		
CPAP (Continuous positive airway pressure)						
Other:						

TREATMENT

❖ Antibiotics:

Starting Date | | | | | | | | | Weaning Date | | | | | | | | |

❖ Oxygen:

Starting Date | | | | | | | | | Weaning Date | | | | | | | | |

Median | | | | | | | | | Consumption (L /Day) | | |

❖ Steroid:

Starting Date | | | | | | | | | Weaning Date | | | | | | | | |

❖ Antivirals:

Starting Date | | | | | | | | | Weaning Date | | | | | | | | |

❖ Bronchodilators:

Starting Date | | | | | | | | | Weaning Date | | | | | | | | |

Name | | | | | | | | | | | | | | | | | | | | | | | | |

❖ Mechanical Ventilation (Intubation):

Starting Date | | | | | | | | | Weaning Date | | | | | | | | |

❖ CPAP (Continuous Positive Airway Pressure):

| | | | | | | | | | | | | | | | | |

Annexure-II

Investigations

Hematocrit:
Hb:
WBC (leukocytes) count:
Differential leukocytes count
Lymphocytes (%):
Monocytes (%)
Neutrophil (%):
Basophil (%):
Eosinophil (%):
Platelet (Thrombocytes) Count:
ESR:

☐ Chest X-ray done ☐ Yes ☐ No			
☐ Chest X-ray → Findings by radiologist	**Consolidation**	**Infiltration**	**Diffuse ARDS**
☐ Blood Culture →Findings if			
☐ Admitted in ICU ☐ Yes	☐ No		
☐ Date of ICU admission ☐☐	☐☐	☐☐☐☐	
Sepsis ☐ Yes ☐ No			
Physician clinical diagnosis:			
Final Outcome			
☐ Discharged alive	Date of discharge ☐☐ ☐☐ ☐☐☐☐		
☐ Death/Died	Date of death ☐☐ ☐☐ ☐☐☐☐		
Signature			
Name of interviewer			
Date			