National Malaria Elimination Program
Malaria Quality Assurance & Quality Control

MQC: FORM 1
MALARIAL SMEARS FOR VALIDATION (CROSS-CHECKING)
(क्रस चेकको लागि स्लाईड पठाउँदा भर्नुपर्ने फाराम)

Month: _____ Year: _____ Province: _____ District: _____

Health Facility Name: _____

Type: Provincial Hospital ☐ District Hospital ☐ PHC ☐ Designated Centers ☐ Health Post ☐ Private Hospital ☐

Other (Specify): ☐ _____

Total No. of slide examined: ☐ Total No. of Positive: ☐ Total No. of Negative: ☐

S.N.	Slide ID No.	Date Examined (dd/mm/yyyy)	Species	Parasites/µl blood (t,s)	Parasites/µl blood (gametocytes)	Remarks
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						

Total No. of Slide Sent: ☐

Examined by (LT/LA)
Name: _____
Signature: _____

Head of the Facility
Name: _____
Signature: _____

Noted by
Name: _____
Signature: _____

Date of Submission: _____