

ICMR Specimen Referral Form for COVID-19 (SARS-CoV2)

INTRODUCTION

This form is for collection centres/ labs to enter details of the samples being tested for Covid-19. It is mandatory to fill this form for each and every sample being tested. It is essential that the collection centres/ labs exercise caution to ensure that correct information is captured in the form.

INSTRUCTIONS:

- Inform the local / district / state health authorities, especially surveillance officer for further guidance
- Seek guidance on requirements for the clinical specimen collection and transport from nodal officer
- This form may be filled in and shared with the IDSP and forwarded to a lab where testing is planned
- Fields marked with asterisk (*) are mandatory to be filled

SECTION A – PATIENT DETAILS

A.1 TEST INITIATION DETAILS

* Doctor Prescription: Yes No

(If yes, attach prescription; If No, test cannot be conducted)

* Follow up Sample: Yes No

If Yes, Patient ID:

A.2 PERSONAL DETAILS

* Patient Name:

* Age: Years/Months age <1 yr, pls. tick months checkbox)

* Patient in quarantine facility: Yes No

* Gender: Male Female Others

* Present Village or Town:

* Mobile Number:

* District of Present Residence:.....

* Mobile Number belongs to: Self Family

* State of Present Residence:.....

* Nationality:

* Present patient address:

* Downloaded Aarogya Setu App: Yes No

.....

(These fields to be filled for all patients including foreigners)

Pincode:

Aadhar No. (For Indians):

Passport No. (For Foreign Nationals):

* A.3 SPECIMEN INFORMATION FROM REFERRING AGENCY

* Specimen type TS/NPS/NS BAL/ETA

* Collection date

* Sample ID (Label)

* A.4 PATIENT CATEGORY (PLEASE SELECT ONLY ONE)

- Cat 1: Symptomatic international traveller in last 14 days.....
- Cat 2: Symptomatic contact of lab confirmed case.....
- Cat 3: Symptomatic healthcare worker.....
- Cat 4: SARI (Severe Acute Respiratory Illness) patient.....
- Cat 5a: Asymptomatic direct and high risk contact of lab confirmed case
- Cat 5b: Asymptomatic healthcare worker in contact with confirmed case without adequate protection...
- Cat 6: Symptomatic Influenza Like Illness (ILI) patient in MoHFW identified clusters.....
- Cat 7: Pregnant woman in/near labour.....
- Other:.....

(Please select "other" only if the patient doesn't fall in any other category)

SECTION B- MEDICAL INFORMATION

B.1 CLINICAL SYMPTOMS AND SIGNS

Symptoms: Yes NO If No please go to B.2 section

Symptoms	Yes	Symptoms	Yes	Symptoms	Yes	Symptoms	Yes	Symptoms	Yes
Cough	<input type="checkbox"/>	Diarrhoea	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	Fever at evaluation	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>
Breathlessness	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Haemoptysis	<input type="checkbox"/>	Body ache	<input type="checkbox"/>		
Sore throat	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	Nasal discharge	<input type="checkbox"/>	Sputum	<input type="checkbox"/>		

Which of the above mentioned was First Symptom:..... Date of onset of First Symptom: (dd/mm/yy)

B.2 PRE-EXISTING MEDICAL CONDITIONS

Condition	Yes	Condition	Yes	Condition	Yes	Condition	Yes
Chronic lung disease	<input type="checkbox"/>	Malignancy	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	Chronic liver disease	<input type="checkbox"/>
Chronic renal disease	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>		
Immunocompromised condition: YES <input type="checkbox"/> NO <input type="checkbox"/>				Other underlying conditions:			

B.3 HOSPITALIZATION DETAILS

Hospitalized: Yes No Hospital State:
 Hospitalization Date: // (dd/mm/yy) Hospital District:
 Hospital Name:

B.4 REFERRING DOCTOR DETAILS

*Name of Doctor: Doctor Mobile No.:
 Doctor Email ID:

* Fields marked with asterisk are mandatory to be filled

TEST RESULT (To be filled by Covid-19 testing lab facility)

Date of sample receipt(dd/mm/yy)	Sample accepted/ Rejected	Date of Testing (dd/mm/yy)	Test result (Positive / Negative)	Repeat Sample required (Yes / No)	Sign of Authority (Lab in charge)