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: …………………………………………
* Patient in quarantine facility: Yes ☐ No ☐
* Present Village or Town: ……..………………….....…
* District of Present Residence:……………………..
* State of Present Residence:………………………..
* Present patient address: ……………………………

…………………………………………………………….

Pincode: ☐☐☐☐☐☐

* Age: …. Years/Months ☐ age <1 yr, pls. tick months checkbox)
* Gender: Male ☐ Female ☐ Others ☐
* Mobile Number: ☐☐☐☐☐☐☐☐☐☐
* Mobile Number belongs to: Self ☐ Family ☐
* Nationality: …………………………………………..
* Downloaded Aarogya Setu App: Yes ☐ No ☐

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

Aadhar No. (For Indians): ☐☐☐☐☐☐☐☐☐☐☐☐

Passport No. (For Foreign Nationals): ……………………..

* A.3 SPECIMEN INFORMATION FROM REFERRING AGENCY

* Specimen type	Throat Swab ☐	Nasal Swab ☐	BAL ☐	ETA ☐	Nasopharyngeal swab ☐
* 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 / Frontline workers .... ☐

Cat 4: Hospitalized SARI (Severe Acute Respiratory Illness) patient……….............…….. ☐

Cat 5a: Asymptomatic direct and high risk contact of lab confirmed case - family member .... ☐

Cat 5b: Asymptomatic healthcare worker in contact with confirmed case without adequate protection.........................… ☐

Cat 6: Symptomatic Influenza like Illness (ILI) in Hospital...………….............................. ☐

Cat 7: Pregnant woman in / near labour………….. ☐

Cat 8: Symptomatic (ILI) amongh returnees and migrants (within 7 days of illness)...……….. ☐

Cat 9: Symptomatic Influenza Like Illness(ILI) patient in Hotspot / Containment zones...................................……….. ☐

Other: (please specify) * *(Select "other" only if the patient doesn't belong to category 1-8)* ☐

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	☐	Diarrhoea	☐	Vomiting	☐	Fever at evaluation	☐	Abdominal pain	☐
Breathlessness	☐	Nausea	☐	Haemoptysis	☐	Body ache	☐		
Sore throat	☐	Chest pain	☐	Nasal discharge	☐	Sputum	☐		

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	☐	Malignancy	☐	Heart disease	☐	Chronic liver disease	☐
Chronic renal disease	☐	Diabetes	☐	Hypertension	☐		

Immunocompromised condition: YES ☐ **NO** ☐ **Other underlying conditions:** ……

B.3 HOSPITALIZATION DETAILS

Hospitalized: Yes ☐ **No** ☐ **Hospital State:** ……

Hospital ID / number **Hospital District:** ……

Hospitalization Date: ☐☐/☐☐/☐☐ (dd/mm/yy) **Hospital Name:** ……

B.4 REFERRING DOCTOR DETAILS

Doctor Mobile No.: ……

***Name of Doctor:** ……..... **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)