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 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)* ☐

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Signature of Patient:

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*

Signature of Patient:

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)

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