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)

***Repeat Sample: Yes ☐ No ☐**

If Yes, Patient ID: ....

A.2 PERSONAL DETAILS

***Patient Name:** ....

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

***Present Village or Town:** ....

***Gender: Male ☐ Female ☐ Others ☐**

***District of Present Residence:**...........................

***Mobile Number:** ☐☐☐☐☐☐☐☐☐☐

***State of Present Residence:**.............................

***Mobile Number belongs to: Self ☐ Family ☐**

***Present patient address:** ....

***Nationality:** ....

....

***Downloaded Aarogya Setu App: Yes ☐ No ☐**

***Pincode:** ☐☐☐☐☐☐

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

Email: ....

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

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

*A.3 SPECIMEN INFORMATION FROM REFERRING AGENCY

***Specimen type**	**TS/NPS/NS** ☐	**BAL/ETA** ☐	**Blood in EDTA** ☐	**Acute sera** ☐	**Covalescent sera** ☐	**Other** ☐
***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: Hospitalized 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 hospital/ MoHFW identified clusters............ ☐

Other:... ☐

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

*A.5 STATUS OF CURRENT RESPIRATORY INFECTION

* **Respiratory infection:** Severe Acute Respiratory Illness (SARI): Yes ☐ No ☐ , Influenza Like Illness (ILI): Yes ☐ No ☐

SECTION B- MEDICAL INFORMATION

B.1 EXPOSURE HISTORY(2 WEEKS BEFORE THE ONSET OF SYMPTOMS)

1. Did you travel to foreign country in last 14 days: ☐ Yes ☐ No

If yes, place(s) of travel: ....,

2. Have you been in contact with lab confirmed COVID-19 patient: Yes ☐ No ☐

If yes, name of confirmed patient: ....

3. *Were you Quarantined?: Yes ☐ No ☐ *If yes, where were you quarantined: Home ☐ Facility ☐

4. Are you a health care worker working in hospital involved in managing patients: ☐ Yes ☐ No

B.2 CLINICAL SYMPTOMS AND SIGNS

Date of onset of symptoms: ☐☐ / ☐☐ / ☐☐ (dd/mm/yy) First Symptom: ....

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	☐		

B.3 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.4 HOSPITALIZATION DETAILS

Hospitalized: Yes ☐ No ☐

Hospital State: ....

Hospital District: ....

Hospitalization Date: ☐ ☐/ ☐ ☐/ ☐ ☐ (dd/mm/yy)

Hospital Name: ....

B.5 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)