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: …………………………………………
*Present Village or Town: ……………………………
*District of Present Residence: ………………………
*State of Present Residence: …………………………..
(These fields to be filled for all patients including foreigners)
*Age: … Years/Months [ ] (If age <1 yr, pls. tick months checkbox)
*Gender: Male [ ] Female [ ] Others [ ]
*Mobile Number: ………………………………………
*Mobile Number belongs to: Self [ ] Family [ ]
*Nationality: …………………………………………………
Present patient address: ……………………………
Pincode: …………………………………………………
Email: …………………………………………………
*Downloaded Aarogya Setu App: Yes [ ] No [ ]

A.3 SPECIMEN INFORMATION FROM REFERRING AGENCY
*Specimen type
BAL/ETA [ ] TS/NPS/NS [ ] Blood in EDTA [ ] Acute sera [ ] Coalescent sera [ ] Other [ ]
*Collection date
*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. …………………………………………
Others. …………………………………………………………………………………………………………………
(Please select "others" 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: …………………………………………………., Stay/travel duration: [ ] / [ ] / [ ] to [ ] / [ ] / [ ] (dd/mm/yy)

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: ………………………………………………….

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Yes</th>
<th>Symptoms</th>
<th>Yes</th>
<th>Symptoms</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cough</td>
<td></td>
<td>Diarrhoea</td>
<td></td>
<td>Vomiting</td>
<td></td>
</tr>
<tr>
<td>Breathlessness</td>
<td></td>
<td>Nausea</td>
<td></td>
<td>Haemoptysis</td>
<td></td>
</tr>
<tr>
<td>Sore throat</td>
<td></td>
<td>Chest pain</td>
<td></td>
<td>Nasal discharge</td>
<td></td>
</tr>
<tr>
<td>Sputum</td>
<td></td>
<td>Abdominal pain</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### B.3 PRE-EXISTING MEDICAL CONDITIONS

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>Condition</th>
<th>Yes</th>
<th>Condition</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic lung disease</td>
<td></td>
<td>Malignancy</td>
<td></td>
<td>Heart disease</td>
<td></td>
</tr>
<tr>
<td>Chronic renal disease</td>
<td></td>
<td>Diabetes</td>
<td></td>
<td>Hypertension</td>
<td></td>
</tr>
<tr>
<td>Immunocompromised condition:</td>
<td></td>
<td>Other underlying conditions:</td>
<td></td>
<td>(HISTORY)</td>
<td></td>
</tr>
<tr>
<td>YES/ NO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### B.4 HOSPITALIZATION DETAILS

Hospitalized: [ ] Yes [ ] No
Hospitalization Date: ……………………………… (dd/mm/yy)
Hospital State: …………………………………………
Hospital District: ……………………………………..
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)

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