

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

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

*Nationality:

Present patient address:

Passport No. (For Foreign Nationals):

Pincode:

Aadhar No. (For Indians):

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 NoIf 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:

Symptoms	Yes	Symptoms	Yes	Symptoms	Yes	Symptoms	Yes	From (dd/mm)	To (dd/mm)
Cough	<input type="checkbox"/>	Diarrhoea	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	Fever at evaluation	<input type="checkbox"/> if yes,	<input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/>
Breathlessness	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Haemoptysis	<input type="checkbox"/>	Body ache	<input type="checkbox"/> if yes,	<input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/>
Sore throat	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	Nasal discharge	<input type="checkbox"/>				
Sputum	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>						(HISTORY)

B.3 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/ NO.....

Other underlying conditions:

B.4 HOSPITALIZATION DETAILSHospitalized: 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)