

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 Covalent 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

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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: <input type="checkbox"/> Yes <input type="checkbox"/> No									
If yes, place(s) of travel:									
2. Have you been in contact with lab confirmed COVID-19 patient: Yes <input type="checkbox"/> No <input type="checkbox"/>									
If yes, name of confirmed patient:									
3. *Were you Quarantined?: Yes <input type="checkbox"/> No <input type="checkbox"/> *If yes, where were you quarantined: Home <input type="checkbox"/> Facility <input type="checkbox"/>									
4. Are you a health care worker working in hospital involved in managing patients: <input type="checkbox"/> Yes <input type="checkbox"/> No									
B.2 CLINICAL SYMPTOMS AND SIGNS									
Date of onset of symptoms <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> (dd/mm/yy)					First Symptom:				
Symptoms	Yes	Symptoms	Yes	Symptoms	Yes	Symptoms	Yes	Symptoms	Yes
Cough	<input type="checkbox"/>	Diarrhoea	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	Fever at evaluation	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>
Breathlessness	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Haemoptysis	<input type="checkbox"/>	Body ache	<input type="checkbox"/>		
Sore throat	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	Nasal discharge	<input type="checkbox"/>	Sputum	<input type="checkbox"/>		
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 <input type="checkbox"/> NO <input type="checkbox"/>				Other underlying conditions:					
B.4 HOSPITALIZATION DETAILS									
Hospitalized: Yes <input type="checkbox"/> No <input type="checkbox"/>					Hospital State:				
Hospitalization Date: <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> (dd/mm/yy)					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)

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)

Registration No. by ICMR - METRO001

General/COVID-19/Format-13/V-II



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