

SAMPLE ID: QS-90619543-2

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 ☐ *Follow up Sample: Yes ☐ No ☐
(If yes, attach prescription; If No, test cannot be conducted) If Yes, Patient ID: _____

A.2 PERSONAL DETAILS

*Patient Name: N. PAVAN SAI CHARAN KUMAR
*Patient in quarantine facility: Yes ☐ No ☐ *Age: 19 Years/Month ☐ (If age=1 yr, pls. tick months checkbox)
*Present Village or Town: ETUKUR
*District of Present Residence: GUNTUR *Gender: Male ☒ Female ☐ Others ☐
*State of Present Residence: Andhra pradesh *Mobile Number: 9705966733
*Present patient address: eatukur road *Mobile Number belongs to: Self ☒ family ☐
Pincode: 522017 *Nationality: Indian
*Downloaded Aarogya Setu App: Yes ☒ No ☐
(These fields to be filled for all patients including foreigners)

Aadhar No. (For Indians): 579931455075

Passport No. (For Foreign Nationals): _____

*A.3 SPECIMEN INFORMATION FROM REFERRING AGENCY

*Specimen type Throat Swab ☐ Nasal Swab ☒ BAL ☐ ETA ☐ Nasopharyngeal swab ☐
*Collection date 12-02-2022 01:23:05 PM
*Sample ID (Label) QS-90619543-2

*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) amongst 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) ☐

SECTION B- MEDICAL INFORMATION

B.1 CLINICAL SYMPTOMS AND SIGNS

Symptoms:	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>	If No please go to B.2 section	
Symptoms Yes	Symptoms Yes	Symptoms Yes	Symptoms Yes	Symptoms Yes
Cough <input checked="" 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"/>	
Which of the above mentioned was First Symptom:		Date of onset of First Symptom (dd/mm/yy) 2011-02-22 00:00:00		
Cough				

B.2 PRE-EXISTING MEDICAL CONDITIONS

Condition Yes	Condition Yes	Condition Yes	Condition Yes
Chronic lung diseases <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 checked="" type="checkbox"/>		Other underlying conditions:	

B.3 HOSPITALIZATION DETAILS

Hospitalized:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hospital State:	Andhra Pradesh
Hospital ID / number	<input type="text"/>	Hospital District:	
Hospitalization Date:	(dd/mm/yy)	Hospital Name:	

B.4 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)
12-02-2022 01:23:05 PM	ACCEPTED	13-02-2022 05:49:51 AM	NEGATIVE		