



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**

*Sample collected first time : Yes ☒ No ☐

If No, Patient ID :

A.2 PERSONAL DETAILS

*Patient Name: **DEVARSHI VADADKAR**

Father's Name:

*Age: **20** Years

*Gender: Male ☒ Female ☐ Transgender ☐

*Occupation: **Other**

*Mobile Number: **9571005925**

*Mobile Number belongs to: Patient ☐ Family ☒

*Nationality: **India**

*Present patient address: **GOVERNMENT QUATER**

*Downloaded Aarogya Setu App: Yes ☐ No ☒

Pincode: **Urban**

*District : **PARBHANI**

*State : **MAHARASHTRA**

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

Aadhaar No. (For Indians):

* Passport No. (for Foreign Nationals):

Received COVID-19 vaccine Yes ☐ No ☒

If yes type of vaccine

Date of Dose 1 : Dose 2 : **No** Date of Dose 2 :

***A.3 SPECIMEN INFORMATION FROM REFERRING AGENCY**

*Specimen type Throat Swab ☒ Nasal Swab ☐ Bronchoalveolar lavage ☐ Endotracheal Aspirate ☐ Nasopharyngeal Swab ☐

*Type of test **RT-PCR** ☒ **Rapid Antigen Test (RAT)** ☐

*Collection date **08/01/2022**

*Sample ID(Label) **1**

If, RT-PCR test, name of lab where sample is sent for testing **CSDHPBM - Civil Surgeon, District Hospital, Parbhani**

* Mode of Transport used to visit testing facility

Symptomatic ☐ Asymptomatic ☒

Contact of a lab confirmed case : Yes ☐ No ☒

Please Note - Hospital form is required for the patients visiting OPD, IPD and Emergency and Community form is required for patients under containment zone/ Non-containment area/ Point of entry/ Testing on demand

***A.3.1 For Community**

Sample collected from **Non-containment Zone**

Cat 4: Testing on Demand ☒

A.3.2 For Hospital*Not Applicable**** Fields marked with asterisk are mandatory to be filled**Please Note: Section B1 and B2 need to be filled for both Community and Hospital settings.**Section B3 needs to be filled only for Hospital settings***Section B- MEDICAL INFORMATION****B.1 CLINICAL SYMPTOMS AND SIGNS**

Cough	<input type="checkbox"/>	Loss of taste	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	Diarrhoea	<input type="checkbox"/>
Fever	<input type="checkbox"/>	Breathlessness	<input type="checkbox"/>
Loss of smell	<input type="checkbox"/>	Other symptoms, please specify	
Date of onset of First Symptom :			

B.2 PRE-EXISTING MEDICAL CONDITIONS

Diabetes	<input type="checkbox"/>	Over weight/ Obesity	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>
Chronic lung disease	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
Chronic Kidney disease	<input type="checkbox"/>	Any other please specify	

B.3 HOSPITALIZATION DETAILS**Not Applicable****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 the Authority(Lab in charge)