SAMPLE ID: 37646197

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: PAVAN KALYAN KONUDULA

*Patient in quarantine facility: Yes ☐ No ☐

*Present Village or Town: MUTYLA REDDY NAGAR-01

*District of Present Residence: GUNTUR

*State of Present Residence: Andhra pradesh

*Present patient address:
MUTYALAREDDY NAGAR 4TH LANE GUNTUR

Pincode: 522007

*Age: 22 Years/Month ☐ (If age=1 yr, pls. tick months checkbox)

*Gender: Male ☑ Female ☐ Others ☐

*Mobile Number: 8328523531

*Mobile Number belongs to: Self ☑ family ☐

*Nationality: Indian

*Downloaded Aarogya Setu App: Yes ☐ No ☑

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

Aadhar No. (For Indians): 8328523531

Passport No. (For Foreign Nationals):

*A.3 SPECIMEN INFORMATION FROM REFERRING AGENCY

*Specimen type Throat Swab ☐ Nasal Swab ☐ BAL ☐ ETA ☐ Nasopharyngeal swab ☑

*Collection date 22-01-2022 01:07:33 PM

*Sample ID (Label) 37646197

*A.4 PATIENT CATEGORY (PLEASE SELECT ONLY ONE)

Category		
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) amongh 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 ☐   No ☑   If No please go to B.2 section

Symptoms	Yes	Symptoms	Yes	Symptoms	Yes	Symptoms	Yes	Symptoms	Yes
Cough	☐	Diarrhoea	☐	Vomiting	☐	Fever at evaluation	☐	Abdominal pain	☐
Breathlessness	☐	Nausea	☐	Haemoptysis	☐	Body ache	☐		
Sore throat	☐	Chest pain	☐	Nasal discharge	☐	Sputum	☐		

Which of the above mentioned was First Symptom: Date of onset of First Symptom (dd/mm/yy) 0000-00-00 00:00:00

B.2 PRE-EXISTING MEDICAL CONDITIONS

Condition	Yes	Condition	Yes	Condition	Yes	Condition	Yes
Chronic lung diseas	☐	Malignancy	☐	Heart disease	☐	Chronic liver disease	☐
Chronic renal disease	☐	Diabetes	☐	Hypertension	☐		

Immunocompromised condition: Yes ☐   No ☑   Other underlying conditions:

B.3 HOSPITALIZATION DETAILS

Hospitalized: Yes ☐   No ☐   Hospital State: **Andhra Pradesh**

Hospital ID / number [_____]

Hospitalization Date: (dd/mm/yy)   Hospital District: -----------------------

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)
22-01-2022 01:07:33 PM	ACCEPTED	22-01-2022 07:48:55 PM	POSITIVE		