SAMPLE ID: 46705896

ICMR Specimen Referral Form for COVID-19 (SARS-CoV2)

INTRODUCTION:

This f m is for collection centres/ labs to enter details of the samples being tested for Covid-19. It is m ndatory to fill th s form for each and every sample being t st d. It is essential that the collection centres/ labs exercise cau to ensu e that correct information is captured in the form.

STRUCTIONS:

- Info the l cal / district / ta e h alth author ties, specially surveillance offic r for fu ther guidance
- Se k guidance n requirement fo the linical specimen co ection and transport from nodal officer
- Thi form may be filled i and sha d with e IDSP and forw ded to a lab where testing is planned
- Fields mark d wi h sterisk (*) ar man atory 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: ----------

2 PERSON L DETAILS

*Patient Name: SURISETTY TRINADHA SANTHOSH KUMAR

in quarantine facility: Ye ☐ No ☐ Age: 21 Years/Mon h ☐ (If age=1 yr, pls. tick months checkbox)

resent Village or Town: M V PETA

Distric of Present Residence: VISAKHAPATNAM Gender: Mal ☑ Female ☐ Others ☐

Stat of Present Residence: Andhra Pradesh Mobile Number: 9550610546

patient address: belongs to: Self ☑ family ☐

Munagapaka Nationality: Indian

P ncode: 531033 Downloaded Aarogya Setu App: Yes ☐ No ☑

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

Aadhar No. (For Indians): 7776 4546 1271

Pas port No. (For Foreign Nationals):

*A.3 SPEC MEN INFORMA ION FROM REFERRING AGENCY

*Spec men ype Throat Sw b ☐ Nasal Swab ☐ BAL ☐ ETA ☐ Nasopharyngeal swab ☑

Collec i n date 21-01-2022 10:25:54 AM

Sample D (Label) 46705896

4 PATIENT CATEGORY (PLEASE SELECT ONLY ONE)

Cat 1: Symptomatic nt national traveller in last 14 days ☐

2: Symptomatic contact f lab confirmed c e ☐

3 Health are wo ker / Fro line workers ☐

4 Hospitalize SARI (Sev re A ute Respiratory Illness) pati nt ☐

5 : As mptomat c direct a d high risk co tact of lab c nfirmed ca - fam y member ☐

b: Asy ptomatic healthcare worke in contact with c nfirmed case withou adequat pr tec ion. ☐

6: Symptomatic Influenza like Il ness (LI) in Hospital ☐

7: Pregnant woman in / near lab ur ☐

8 (ILI) am ngh return es and migrants (within 7 day of il n ss) ☐

9 Like Illness patient Hotspot / ontain en zones ☐

Other: (pl a s e ify) ** (Sel ct "other" only if the a ent d esn't belong to categor 1-8)* ☐

SECTION B- MEDICAL INFORMATION

B.1 CLINICAL SYMPTOMS AND SIGNS

Sym toms: Yes ☐ o ☑ **If No please go to B.2 sec ion**

Sy ptoms Yes	Symptoms Yes	Symptoms Yes	Symptoms Yes	Symptoms Yes
Cough ☐	Diarrh ea ☐	Vo iting ☐	Fever at evalu ion ☐	Abdominal pain ☐
Breathlessness ☐	Nausea ☐	Haemoptys s ☐	Body ache ☐	
ore hroat ☐	Che t pain ☐	N sal discharge ☐	putum ☐	

Which of the above mentioned was First Symptom: ----------

Date of onset of First Symptom (dd/mm/yy) 0000-00-00 00:00:00

2 PRE-EXISTING MEDICAL CONDITIONS

C ndition Yes	Condition Yes	Condition Yes	Condition Yes
r nic lung diseas ☐	Malignancy ☐	Heart disease ☐	hronic liver disease ☐
renal disease ☐	Diabetes ☐	yper ension ☐	

Immunocompromised condition: Yes ☐ N ☑ **Other underlying conditions:**

3 HOSPITALIZATION DETAILS

Hospitalized: Yes ☐ No ☐

ID / nu ber ☐

ation Dat : (dd/mm/yy)

Hospital State: Andhra Pradesh

Dis r ct: ----------

Name: ----------

4 REFERRING DOCTOR DETAILS

***Name of Doct r:** ----------

ctor Mobile No: ----------

Email ID: ----------

** Fields marked with asterisk are mandatory to be filled*

T ST RESULT (To be filled by Covid-19 testing lab facility)

Date f 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)
21-01-2022 12:53:54 AM	ACCEPTED	22-01-2022 07:45:25 PM	NEGATIVE		