

SAMPLE ID: 55693329

## 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, specially surveillance officer for further guidance
- Seek guidance on requirement 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: \_\_\_\_\_

**2 PERSONAL DETAILS**

\*Patient Name: MATHAMSETTI S S N V G P AKHIL  
 in quarantine facility: Yes ☐ No ☐ Age: 21 Years / Months ☐ (If age=1 yr, pls. tick months checkbox)  
 Present Village or Town: PERAVARAM  
 District of Present Residence: EAST GODAVARI  
 State of Present Residence: Andhra Pradesh  
 patient address: \_\_\_\_\_ belongs to: Self ☒ family ☐  
Peravaram Nationality: Indian  
 P ncode: 533235 Downloaded Aarogya Setu App: Yes ☐ No ☒  
*(These fields to be filled for all patients including foreigners)*

Aadhar No. (For Indians): 2155 8019 0463

Passport No. (For Foreign Nationals): \_\_\_\_\_

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

\*Specimen type Throat Swab ☐ Nasal Swab ☐ BAL ☐ ETA ☐ Nasopharyngeal swab ☒  
 Collection date 20-01-2022 10:53:54 AM  
 Sample ID (Label) 55693329

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

Cat 1: Symptomatic international traveller in last 14 days \_\_\_\_\_ ☐  
 2: Symptomatic contact of lab confirmed case \_\_\_\_\_ ☐  
 3: Health care worker / Frontline workers \_\_\_\_\_ ☐  
 4: Hospitalized SARI (Severe Acute Respiratory Illness) patient \_\_\_\_\_ ☐  
 5: Asymptomatic direct and high risk contact of lab confirmed case - family member \_\_\_\_\_ ☐  
 6: Asymptomatic healthcare worker in contact with confirmed case without adequate protection. \_\_\_\_\_ ☐  
 7: Symptomatic Influenza like Illness (ILI) in Hospital \_\_\_\_\_ ☐  
 8: Pregnant woman in / near labour \_\_\_\_\_ ☐  
 9: (ILI) among returnees and migrants (within 7 days of illness) \_\_\_\_\_ ☐  
 10: Like Illness patient 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
Cough <input type="checkbox"/>	Diarrhea <input type="checkbox"/>	Vomiting <input type="checkbox"/>	Fever at evaluation <input type="checkbox"/>
Breathlessness <input type="checkbox"/>	Nausea <input type="checkbox"/>	Haemoptysis <input type="checkbox"/>	Body ache <input type="checkbox"/>
More 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) 0000-00-00 00:00:00

### 2 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"/>
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:	

### 3 HOSPITALIZATION DETAILS

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

### 4 REFERRING DOCTOR DETAILS

*Name of Doctor: <input type="text"/>	Doctor Mobile No: <input type="text"/>
	Email ID: <input type="text"/>

\* 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)
20-01-2022 10:53:54 AM	ACCEPTED	20-01-2022 07:45:25 PM	NEGATIVE		