SRF ID (RTPCR):



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

**0 8 1 0 2 0 1 5 7 0 7 2 9**

# 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: **LALITA DEVI** Father's Name:

\*Age: **69** Years

\*Gender:Male  Female  Transgender 

\*Occupation:**Other**

\*Mobile Number: **9 8 0 5 1 9 3 3 7 6** \*Mobile Number belongs to: Patient Family

\*Nationality: **India**

\*Present patient address: **13 SANT** \*Downloaded Aarogya Setu App: Yes No

# BANDHU COLONY NEAR ALKA CINEMA VISHWAKARMA

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **-** | **-** | **-** | **-** | **-** | **-** |

**INDUSTRIAL AREA JAIPUR** Pincode:

\*District : **JAIPUR** \*State : **RAJASTHAN**

(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 

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

\*Collection date **07/05/2021**

\*Sample ID(Label) **111759453**

Endotracheal

Aspirate 

Nasopharyngeal Swab 

If, RT-PCR test, name of lab where sample is sent for testing **RDCPLJR - Reliable Diagnostic Centre Pvt. Ltd., Jaipur**

\* 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 3: All symptomatic (ILI symptoms) individuals with history of international travel in the last 14 days

**\*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 Loss of taste



Sore throat  Diarrhoea 

Fever  Breathlessness 

Loss of smell  Other symptoms, please specify

Date of onset of First Symptom :

**B.2 PRE-EXISTING MEDICAL CONDITIONS**

Diabetes Over weight/ Obesity

Heart disease  Hypertension 



Chronic lung disease  Cancer 

Chronic Kidney disease 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) |
|  |  |  |  |  |  |