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

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| **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 | | | | | | | | | | | | | | | | | | | | | |
| **SECTION A – MANDATORY FIELDS (FORM WILL NOT BE ACCEPTED IN CASE OF ANY BLANK)** | | | | | | | | | | | | | | | | | | | | | |
| **\*A.1 PERSON DETAILS** | | | | | | | | | | | | | | | | | | | | | |
| **\*Patient Name:** ……………………………………….  **\*Present Patient Village or Town:**  …….…………………..  **\*District of present residence**:…………………………  **\*State of present residence**:……………………………  *(These fields to be filled for all patients including foreigners)* | | | | | | **\*Age: ….Years…..Month , Gender: \* Male Female Others**  **\*Mobile Number: \_**  **\*Mobile Number belongs to: Self Family Other**  **\*Nationality:** ………………………………………….. | | | | | | | | | | | | | | | |
| **\*A.2 SPECIMEN INFORMATION FROM REFERRING AGENCY** | | | | | | | | | | | | | | | | | | | | | |
| **\*Specimen type** | **BAL/ETA** |  |  |  | **TS/NPS/NS** |  | **Blood in EDTA** |  |  |  |  |  | **Acute sera** |  |  |  |  | **Covalescent sera** |  |  | **Other** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **\*Collection date** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **\*Label** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **\*Is it a repeated sample? Yes No**  **\*Sample collection facility name: …………………… \*Collection facility pin-code** | | | | | | | | | | | | | | | | | | | | | |
| **\*A.3 PATIENT CATEGORY (PLEASE SELECT ONLY ONE)** | | | | | | | | | | | | | | | | | | | | | |
| Cat 1: Symptomatic international traveller in last 14 days…………………………………………………..  Cat 2: Symptomatic contact of lab confirmed case…………………………………………………………...  Cat 3: Symptomatic healthcare worker………………………………………………………………………..  Cat 4: Hospitalized SARI (Severe Acute Respiratory Illness) patient……………………………………......  Cat 5a: Asymptomatic direct and high risk contact of confirmed case – family member………………….  Cat 5b: Asymptomatic healthcare worker in contact with confirmed case without adequate protection… | | | | | | | | | | | | | | | | | | | | | |
| **Section B- OTHER FIELDS TO BE UPDATED** | | | | | | | | | | | | | | | | | | | | | |
| **B.1 PERSON DETAILS** | | | | | | | | | | | | | | | | | | | | | |
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| **Present patient address:**  …………..………………………..  ……………………………………………………………… **Email id**:……………………………………………………. **Patient Aadhar No. (For Indians)** | | | | | | **Pin code:**  **Date of Birth: / / (dd/mm/yy)**  **Patient Passport No. (for Foreign national only**)……………… | | | | | | | | | | | | | | | |
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| **B.2 EXPOSURE HISTORY(2 WEEKS BEFORE THE ONSET OF SYMPTOMS)** | | | | | | | | | | | | | | | | | | | | | |
| 1. **Did you travel to foreign country in last 14 days: Yes No**   **If yes, place(s) of travel:** ………………………**, Stay/travel duration: / / to / / (dd/mm/yy)**   1. **Have you been in contact with lab confirmed COVID-19 patient: Yes No If yes, name of confirmed patient:** …………………………….. 2. **Were you Quarantined?: Yes No If yes, where were you quarantined: Home Facility** 3. **Are you a health care worker working in hospital involved in managing patients: Yes No** | | | | | | | | | | | | | | | | | | | | | |

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| **B.3 CLINICAL SYMPTOMS AND SIGNS** | | | | | | | | | | | |
| **Date of onset of symptoms:** | |  |  | **/** |  |  | **/** |  |  | **(dd/mm/yy) First Symptom:** ………………………………… | |
|  | | | | | | | | | | | |
| **Symptoms Yes Symptoms Yes Symptoms Yes Symptoms Yes From (dd/mm) To (dd/mm) Cough Diarrhoea Vomiting Fever at evaluation if yes, / / Breathlessness Nausea Haemoptysis Body ache if yes, / /**  **Sore throat Chest pain Nasal discharge**  **Sputum Abdominal pain (HISTORY)** | | | | | | | | | | | |
| **Respiratory infection at sample collection: Severe Acute Respiratory Illness (SARI): Yes No , ARI: Yes No** | | | | | | | | | | | |
|  | **B.4 UNDERLYING MEDICAL CONDITIONS** | | | | | | | | | |  |
| **Condition Yes Condition Yes Condition Yes Condition Yes COPD Bronchitis Diabetes Hypertension Chronic renal disease Malignancy Heart disease Asthma**  **IMMUNOCOMPROMISED CONDITION: YES/ NO**…………………….. **Other underlying conditions:** ……………………… | | | | | | | | | | | |
|  | **B.5 HOSPITALIZATION, TREATMENT AND INVESTIGATION** | | | | | | | | | |  |
| **Hospitalization date: / / (dd/mm/yy) DIAGNOSIS:** …………………………………..  **DIFFERENTIAL DIAGNOSIS:** …………………… **ETIOLOGY IDENTIFIED:** ……………………..  **ATYPICAL PRESENTATION: YES/NO** …………. **UNUSUAL/UNEXPECTED COURSE: YES/NO**  **OUTCOME: Discharge/Death/** …………………... **OUTCOME date: / / (dd/mm/yy)** | | | | | | | | | | | |
| **Phone mobile number:** ……………………………… **Hospital Name/address:** …………………………………..……..  **Name of Doctor:** ……………………………………… **Signature and date: / / (dd/mm/yy)** | | | | | | | | | | | |
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**DETAILS OF HEALTH AUTHORITY (FOR SENDING THE REPORT)**

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Name of Doctor …………………..…… Hospital Name /address …………………………..…..

EMAIL ID ……………………………………………………………………...……………………

Phone /mobile number …………………….. Signature and Date ……………………………...

**For Official Use – To be filled by COVID-19 testing lab facility**

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| Date of sample  receipt(dd/mm/yy) | Sample accepted/  Rejected | Date of  testing | Test result | Repeat Sample  required | Sign of Authority  (Lab in charge) |
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