SRFID (RTPCR): 0 8 1 1 4 0 0 2 8 4 3 4 5

ICMRSpecimenReferralFormforCOVID-19(SARS-CoV2)

INTRODUCTION:

Thisformisforcollectioncentres/labstoenterdetailsofthesamplesbeingtestedforCovid-19.Itismandatorytofillthisformforeach and everysamplebeingtested.Itisessentialthatthecollectioncentres/labsexercisecautiontoensurethatcorrectinformationis capturedinthe form.

INSTRUCTIONS:

- Informthelocal/district/statehealthauthorities,especiallysurveillanceofficerforfurtherguidance
- Seekguidanceonrequirementsfortheclinicalspecimencollectionandtransportfromnodalofficer
- ThisformmaybefilledinandsharedwiththeIDSPandforwardedtoalabwheretestingisplanned Fields
- markedwithasterisk(*)aremandatorytobefilled

SECTION A – PATIENT DETAILS

A.1 TEST INITIATION DETAILS

*Samplecollectedfirsttime: Yes☑ No☐ If No,PatientID:

A.2 PERSONAL DETAILS

*PatientName:**VICKY KUMAR SINGH**
Father'sName:
*Age: **28** Years
*Gender:Male☑ Female☐ Others☐
*Occupation:**Other**
*Mobile Number: 9 8 2 8 4 8 8 3 7 8
*MobileNumberbelongsto:Self☐ Family☑
*Nationality: **India**
*Presentpatientaddress:**GAYA BIHAR**
*DownloadedAarogyaSetuApp:Yes☐ No☑
Pincode:
*District:**GAYA**
*State :**BIHAR**

(These fields tobefilledfor all patients including foreigners)
AadhaarNo.(ForIndians):
*PassportNo.(forForeignNationals):

*A.3 SPECIMEN INFORMATION FROM REFERRING AGENCY

*Specimentype ThroatSwab☑ NasalSwab☐ lavage☐ Endotracheal Aspirate☐ NasopharyngealSwab☐ Bronchoalveolar

*Typeoftest **RT-PCR☑ Rapid Antigen Test (RAT)☐**
*Collectiondate **28/03/2021**
*SampleID(Label) **284345**
If,RT-PCRtest,nameoflabwheresampleissentfortesting**ANMMCH – Anurag Narayan Magadh Medical college, Gaya, Bihar**
*ModeofTransportusedtovisittestingfacility**Private - Car**
Symptomatic☐ Asymptomatic☑
Contactofalabconfirmedcase: Yes☐ No☑

PleaseNote-HospitalformisrequiredforthepatientsvisitingOPD,IPDandEmergencyandCommunityformisrequiredforpatients under containmentzone/Non-containmentarea/Pointofentry/Testingondemand

*A.3.1 For Community

Samplecollectedfrom
Cat 12: Testing on Demand☑

*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	☐	Lossoftaste	☐
Sorethroat	☐	Diarrhoea	☐
Fever	☐	Breathlessness	☐
Lossofsmell	☐	Othersymptoms,pleasespecify	
DateofonsetofFirstSymptom:			

B.2 PRE-EXISTING MEDICAL CONDITIONS

Diabetes	☐	Overweight/Obesity	☐
Heartdisease	☐	Hypertension	☐
Chroniclungdisease	☐	Cancer	☐
ChronicKidneydisease	☐	Anyotherpleasespecify	

B.3 HOSPITALIZATION DETAILS

Not Applicable

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

Dateofsamplereceipt (dd/mm/yy)	Sample accepted/Rejected	Dateoftesting (dd/mm/yy)	Test result (Positive/Negative)	Repeat Sample required(Yes/No)	Sign of the Authority(Labin charge)