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, 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: ..... Father's Name.....

*Age: .... Years/Months/ Days (If age <1 yr, pls. tick months/ days checkbox)

* Gender: Male ☐ Female ☐ Others ☐

*Occupation: Health Care Worker ☐ Police ☐ Sanitation ☐ Security Guards ☐ Others ☐

*Mobile Number: ☐☐☐☐☐☐☐☐☐☐ Mobile Number belongs to: Self ☐ Family ☐

*Nationality: .....

*Present patient address: ..... *Downloaded Aarogya Setu App: Yes ☐ No ☐

..... Pincode ☐☐☐☐☐☐

*District ..... *State:.....

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

Aadhar No. (For Indians):

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

*A.3 SPECIMEN INFORMATION FROM REFERRING AGENCY

*Specimen type: Throat Swab ☐ Nasal Swab ☐ Bronchoalveolar lavage ☐ Endotracheal Aspirate ☐ Nasopharyngeal swab ☐

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

*Name of kit used

*Collection date ☐☐ ☐☐ ☐☐☐☐

*Sample ID (Label)

If, RT-PCR test, name of lab where sample is sent for testing (Drop down – list of Rt-PCR/ TrueNat/ CBNAAT labs)

* Mode of Transport used to visit testing facility Public – In drop down menu – Bus, Metro, Train, Cab, Auto

Private – In drop down menu – Car, Scooty, Bike, Bicycle, Walk

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

Symptomatic ☐ Asymptomatic ☐

Contact of a lab confirmed case: **Yes** **No**

Sample collected from In Drop down menu

Containment Zone
Non-containment area
Testing on demand
Point of entry

Cat 1: All symptomatic (ILI symptoms) cases ☐
Cat 2: All asymptomatic high-risk individuals (Any individual who falls under Section B2) ☐
Cat 3: All symptomatic (ILI symptoms) individuals with history of international travel in the last 14 days ☐

Date of Testing (dd/mm/yy) Test result: Positive ☐ Negative ☐

A.3.2 For Hospital

Cat 4: All patients of Severe Acute Respiratory Infection (SARI).....
Cat 5: All symptomatic (ILI symptoms) patients presenting in a healthcare setting.....
Cat 6: Asymptomatic high-risk patients who are hospitalized or seeking immediate hospitalization.....
Cat 7: Asymptomatic patients undergoing surgical / non-surgical invasive procedures (not to be tested more than once a week during hospital stay).
Cat 8: All pregnant women in/near labour who are hospitalized for delivery.....
Cat 9: All symptomatic neonates presenting with acute respiratory / sepsis like illness.....
Cat 10: Patients presenting with atypical manifestations [stroke, encephalitis, pulmonary embolism, acute coronary symptoms, Guillain Barre syndrome, Multi-system Inflammatory Syndrome in Children (MIS-C), progressive gastrointestinal symptoms] based on the discretion of the treating physician.

** 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(dd/mm/yy): ☐☐ ☐☐ ☐☐

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

Hospitalized: Yes ☐ **No** ☐

Hospital State:
..... **Hospital**
District: .....
Hospital Name:
.....

Hospitalization Date: ☐☐ ☐☐ ☐☐

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)