Dr. B. Lal Clinical Laboratory

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

*Doctor Prescription: Yes ◯ No ◯

(If yes, attach prescription; If No, test cannot be conducted)

*Repeat Sample: Yes ◯ No ◯

If Yes, Patient ID: .....

A.2 PERSONAL DETAILS

*Patient Name: *Age Years/Month or DOB

*Present Village or Town: *Gender: Male ◯ Female ◯ Others ◯

*District of Present Residence: *Mobile Number:

*State of Present Residence: *Mobile Number belongs to: Self ◯ Family ◯

*Present patient address: *Nationality:

*Downloaded Aarogya Setu App: Yes ◯ No ◯

*Pincode:

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

Email: Passport No. (For Foreign Nationals):

Aadhar No. (For Indians):

*A.3 SPECIMEN INFORMATION FROM REFERRING AGENCY

*Specimen type Throat Swab ☐ Nasal Swab ☐ ETA ☐ BAL ☐ Nasopharyngeal Swab ☐

*Collection date *Sample Collected By

*Sample ID (Label) *Samp. Collector's Phone No.

*A.4 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/frontline workers..... ◯

Cat 4: Hospitalized SARI (Severe Acute Respiratory Illness) patient..... ◯

Cat 5a: Asymptomatic direct and high risk contact of lab confirmed case ..... ◯

Cat 5b: Asymptomatic healthcare worker in contact with confirmed case without adequate protection ◯

Cat 6: Symptomatic Influenza Like Illness (ILI) patient in hospital..... ◯

Cat 7: Pregnant woman in/near labour..... ◯

Cat 8: Symptomatic (ILI) among returnees and migrants (within 7days of illness)..... ◯

Cat 9: Symptomatic Influenza like Illness(ILI) patient in Hotspot/Containment zones ..... ◯

Other *Please select "other" only if the patient doesn't fall in any other category)* ..... ◯

SECTION B- MEDICAL INFORMATION

B.1 CLINICAL SYMPTOMS AND SIGNS

Date of onset of symptoms: _____ **First Symptom:** _____

Symptoms	Yes	Symptoms	Yes	Symptoms	Yes	Symptoms	Yes	Symptoms	Yes
Cough	☐	Diarrhoea	☐	Vomiting	☐	Fever at evaluation	☐	Abdominal pain	☐
Breathlessness	☐	Nausea	☐	Haemoptysis	☐	Body ache	☐		
Sore throat	☐	Chest pain	☐	Nasal discharge	☐	Sputum	☐		

B.2 PRE-EXISTING MEDICAL CONDITIONS

Condition	Yes	Condition	Yes	Condition	Yes	Condition	Yes
Chronic lung disease	☐	Malignancy	☐	Heart disease	☐	Chronic liver disease	☐
Chronic renal disease	☐	Diabetes	☐	Hypertension	☐		

Immunocompromised condition: YES ☐ **NO** ☐ **Other underlying conditions:**

B.3 HOSPITALIZATION DETAILS

Hospitalized: Yes ☐ **No** ☐

Hospital ID/ Number _____

Hospitalization Date: _____ (dd/mm/yy)

Hospital State: _____

Hospital District: _____

Hospital Name: _____

B.4 REFERRING DOCTOR DETAILS

***Name of Doctor:** _____

Doctor Mobile No.: _____

Doctor Email ID: _____

** 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)