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

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** ☐ **Transgender** ☐

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

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

***Nationality:** ……..

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

Pincode: …….. ***Location: Urban/ Rural/ Tribal (Select either of the ones)**

***District ……..** ***State** :……

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

Aadhar No. (For Indians): ……

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

***Received COVID-19 vaccine Yes** ☐ **No** ☐

***If yes type of vaccine (in drop down) Covaxin** ☐ **Covishield** ☐ **Sputnik V** ☐

***Date of Dose 1 --/--/----** ***Dose 2 received? – Yes/ No (Mandatory)** **If yes, Date of Dose 2 --/--/---- (Mandatory)**

***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) …….**

Symptomatic ☐ **Asymptomatic** ☐

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

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, Ambulance**

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

☐ **Not Applicable**

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 (In Dropdown) - **Containment Zone/Non-containment area/Point of entry (Select either of the ones)**

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
Cat 4: All individuals who wish to get themselves tested

A.3.2 For Hospital

Cat 1: All patients of Severe Acute Respiratory Infection (SARI)
Cat 2: All symptomatic (ILI symptoms) patients presenting in a healthcare setting
Cat 3: Asymptomatic high-risk patients who are hospitalized or seeking immediate hospitalization
Cat 4: Asymptomatic patients undergoing surgical / non-surgical invasive procedures (not to be tested more than once a week during hospital stay).
Cat 5: All pregnant women in/near labour who are hospitalized for delivery
Cat 6: All symptomatic neonates presenting with acute respiratory / sepsis like illness
Cat 7: 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
Cat 8: All individuals who wish to get themselves tested

**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:** …….

Hospitalization Date: ☐☐ ☐☐ ☐☐

Hospital Name: ……

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)