Specimen Referral Form for COVID-19 (SARS-CoV2) Testing - Form 44

(Approved by ICMR, Reg. # PLH001)

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)

Follow-up Sample: Yes ☐ No ☐

If Yes, Patient ID: .....

*A.2 PERSONAL DETAILS

***Patient Name:** .....

***Age:**..... Years..... Months ☐ (If age <1 yr, pls. tick Months checkbox)

***Patient in Quarantine Facility: Yes** ☐ **No** ☐

***Gender:** Male [ ] Female [ ] Others [ ]

***Present Village or Town:** .....

***Mobile #:** ☐☐☐☐☐☐☐☐☐☐

***District of Present Residence:** .....

***Mobile Number belongs to:** Self [ ] Family [ ]

***State of Present Residence:** .....

***Nationality:**

.....

***Downloaded Aarogya Setu App:** Yes ☐ No ☐

***Present Patient Address:** .....

.....

***Pin Code:** ☐☐☐☐☐☐

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

Email: .....

***Aadhar No. (for Indians):** ☐☐☐☐☐☐☐☐☐☐☐☐

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

*A.3 SPECIMEN INFORMATION FROM REFERRING AGENCY

*Specimen type	BAL/ETA ☐	TS/NPS/NS ☐	Blood in EDTA ☐	Acute sera ☐	Covalescent sera ☐	Other ☐
*Collection date						
*Sample ID (Label)						

*A.4 PATIENT CATEGORY (PLEASE SELECT ONLY ONE)

Cat 1: Symptomatic international travelers in last 14 days ..... ☐

Cat 2: Symptomatic contact of lab confirmed case ..... ☐

Cat 3: Symptomatic healthcare worker ..... ☐

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

Cat 5a: Asymptomatic direct and high-risk contact of 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/ MoHFW identified clusters ..... ☐

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

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

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

Other: please specify * *(Select "other" only if the patient doesn't belong to category 1-8)* ☐

Path Care® COMPLETE DIAGNOSTIC SOLUTION

Specimen Referral Form for COVID-19 (SARS-CoV2) Testing - Form 44

(Approved by ICMR, Reg. # PLH001)

Section B- MEDICAL INFORMATION

B.1 CLINICAL SYMPTOMS AND SIGNS

Symptoms: Yes ☐ No ☐ **If No, please go to Section B.2**

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	☐		

Which of the above mentioned was First Symptom: …… **Date of onset of first symptom:** …… /….. /….. **(dd/mm/yy)**

……

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 State: ……

Hospital ID / Number Hospital District: ……

Hospitalization Date: ☐☐/☐☐/☐☐ (dd/mm/yy) Hospital Name: ……

B.4 REFERRING DOCTOR DETAILS

Doctor Mobile No.: ……

* Name of Doctor: …… 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	Test Result	Repeat Sample Required	Sign of Authority (Lab in-charge)