ICMR Specimen Referral Form for COVID-19 (SARS-CoV2)

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

SECTION A – MANDATORY FIELDS (FORM WILL NOT BE ACCEPTED IN CASE OF ANY BLANK)

*A.1 PERSON DETAILS

***Patient Name:** ……

***Present Patient Village or Town:**

……..……..

***District of present residence:**……

***State of present residence:**……

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

***Age: ….Years…..Month , Gender: * Male ☐ Female ☐ Others ☐**

***Mobile Number:** ☐☐☐☐☐☐☐☐☐☐

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

***Nationality:** ……..

*A.2 SPECIMEN INFORMATION FROM REFERRING AGENCY

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

***Is it a repeated sample? Yes ☐ No ☐**

***Sample collection facility name: ……..** ***Collection facility pin-code** ☐☐☐☐☐☐

*A.3 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…….. ☐

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

Cat 5a: Asymptomatic direct and high risk contact of confirmed case – family member…… ☐

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

Section B- OTHER FIELDS TO BE UPDATED

B.1 PERSON DETAILS

Present patient address:

……..……..

……

Email id:……

Pin code: ☐☐☐☐☐☐

Date of Birth: ☐☐/☐☐/☐☐ **(dd/mm/yy)**

Patient Passport No. (for Foreign national only)……

Patient Aadhar No. (For Indians) ☐☐☐☐☐☐☐☐☐☐☐☐

B.2 EXPOSURE HISTORY(2 WEEKS BEFORE THE ONSET OF SYMPTOMS)

1. Did you travel to foreign country in last 14 days: ☐ Yes ☐ No

If yes, place(s) of travel: ……, Stay/travel duration: ☐☐/☐☐/☐☐ to ☐☐/☐☐/☐☐ (dd/mm/yy)

2. Have you been in contact with lab confirmed COVID-19 patient: Yes ☐ No ☐

If yes, name of confirmed patient: ……..

3. Were you Quarantined?: Yes ☐ No ☐ If yes, where were you quarantined: Home ☐ Facility ☐

4. Are you a health care worker working in hospital involved in managing patients: Yes ☐ No ☐

B.3 CLINICAL SYMPTOMS AND SIGNS

Date of onset of symptoms: ☐☐ /☐☐ /☐☐ (dd/mm/yy) **First Symptom:** ……

Symptoms	Yes	Symptoms	Yes	Symptoms	Yes	Symptoms	Yes	From (dd/mm)	To (dd/mm)
Cough	☐	Diarrhoea	☐	Vomiting	☐	Fever at evaluation	☐ if yes,	☐☐/☐☐	☐☐/☐☐
Breathlessness	☐	Nausea	☐	Haemoptysis	☐	Body ache	☐ if yes,	☐☐/☐☐	☐☐/☐☐
Sore throat	☐	Chest pain	☐	Nasal discharge	☐				
Sputum	☐	Abdominal pain	☐						

(HISTORY)

Respiratory infection at sample collection: Severe Acute Respiratory Illness (SARI): Yes ☐ **No** ☐ **ARI: Yes** ☐ **No** ☐

B.4 UNDERLYING MEDICAL CONDITIONS

Condition	Yes	Condition	Yes	Condition	Yes	Condition	Yes
COPD	☐	Bronchitis	☐	Diabetes	☐	Hypertension	☐
Chronic renal disease	☐	Malignancy	☐	Heart disease	☐	Asthma	☐

IMMUNOCOMPROMISED CONDITION: YES/ NO…….. **Other underlying conditions:** ……

B.5 HOSPITALIZATION, TREATMENT AND INVESTIGATION

Hospitalization date: ☐☐/ ☐☐/ ☐☐ (dd/mm/yy) **DIAGNOSIS:** ……..

DIFFERENTIAL DIAGNOSIS: …… **ETIOLOGY IDENTIFIED:** ……..

ATYPICAL PRESENTATION: YES/NO …… **UNUSUAL/UNEXPECTED COURSE: YES/NO**

OUTCOME: Discharge/Death/ ……... **OUTCOME date:** ☐☐/ ☐☐/ ☐☐ (dd/mm/yy)

Phone mobile number: …… **Hospital Name/address:** ……..……..

Name of Doctor: …… **Signature and date:** ☐☐/ ☐☐/ ☐☐ (dd/mm/yy)

DETAILS OF HEALTH AUTHORITY (FOR SENDING THE REPORT)

Name of Doctor ……..…… Hospital Name /address ……..…..

EMAIL ID ……...……

Phone /mobile number …….. Signature and Date ……...

For Official Use – 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)