

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

(Railway Employees/Pensioners please carry UMID card along with Aadhar)

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

*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: Covaxin Covishield

Date of Dose 1 --/--/---- Date of Dose 2 --/--/----

***A.3 SPECIMEN INFORMATION FROM REFERRING AGENCY**

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

*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 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
- 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 <input type="checkbox"/> Sore Throat <input type="checkbox"/> Fever <input type="checkbox"/> Loss of smell <input type="checkbox"/> Date of onset of First Symptom(dd/mm/yy): <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Loss of taste <input type="checkbox"/> Diarrhoea <input type="checkbox"/> Breathlessness <input type="checkbox"/> Other symptoms, please specify: _____		
B.2 PRE-EXISTING MEDICAL CONDITIONS			
Diabetes <input type="checkbox"/> Heart disease <input type="checkbox"/> Chronic Lung disease <input type="checkbox"/> Chronic Kidney Disease <input type="checkbox"/>	Over weight/ Obesity <input type="checkbox"/> Hypertension <input type="checkbox"/> Cancer <input type="checkbox"/> Any other please specify: _____		
B.3 HOSPITALIZATION DETAILS			
Hospitalized: Yes <input type="checkbox"/> No <input type="checkbox"/>		Hospital State: _____ Hospital	
Hospitalization Date: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		District: 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)