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

Doc No. SP / MOL / FR / 13
Issue I, Rev: 00 Dated: 01 12 2021

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 INTIATION 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:** ……………………………………………….. ***Download Aarogya Setu App**: Yes ☐ No ☐

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

***District:** ………………………….. ***State**: ………………………….

(*These fields to be filled for all patient including foreigners*)

***Aadhar No. (For Indians):** ……………………………………………….. ***Passport No.:** ………………………………………………….

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

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

***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**: ………………………

***Symptomatic** ☐ **Asymptomatic** ☐

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

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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:**

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 A – PATIENT DETAILS
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 Symptoms (dd/mm/yyyy): ________________________

B.2 PRE-EXISTING MEDICAL CONDITIONS

Diabetes ☐ Over weight / Obesity ☐
Heart Disease ☐ Hypertension ☐
Chronic Lung Disease ☐ Cancer ☐
Chronic Kidney Disease ☐ Other Other, please specify: ______________________________

B.3 HOSPITALIZATION DETAILS

Hospitalized: Yes ☐ No ☐ Hospital Name: ………………………………………………………….
Hospitalization Date: __________________ Hospital Dist: ……………………………. Hosp State: …………….

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 incharge)