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

<table>
<thead>
<tr>
<th>Sample collected first time:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If No, Patient ID:</td>
<td>...........................................................</td>
<td></td>
</tr>
</tbody>
</table>

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): ...........................................................  

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

- [ ] 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
- [ ] Sore Throat
- [ ] Fever
- [ ] Loss of smell
- [ ] Loss of taste
- [ ] Diarrhoea
- [ ] Breathlessness
- [ ] 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: ………………………………………

Hospital Name:

………………………………………………

TEST RESULT (To be filled by Covid-19 testing lab facility)

<table>
<thead>
<tr>
<th>Date of sample receipt(dd/mm/yy)</th>
<th>Sample accepted/Rejected</th>
<th>Date of Testing (dd/mm/yy)</th>
<th>Test result (Positive / Negative)</th>
<th>Repeat Sample required (Yes / No)</th>
<th>Sign of Authority (Lab in charge)</th>
</tr>
</thead>
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