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

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: ……………………………………
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 (in drop down) Covaxin ☐ Covishield ☐ Sputnik V ☐
*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 (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 (In Dropdown) - Containment Zone/Non-containment area/Point of entry (Select either of the ones)

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

<table>
<thead>
<tr>
<th>SECTION B- MEDICAL INFORMATION</th>
</tr>
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<tbody>
<tr>
<td><strong>B.1 CLINICAL SYMPTOMS AND SIGNS</strong></td>
</tr>
<tr>
<td>Cough ☐</td>
</tr>
<tr>
<td>Sore Throat ☐</td>
</tr>
<tr>
<td>Fever ☐</td>
</tr>
<tr>
<td>Loss of smell ☐</td>
</tr>
<tr>
<td>Date of onset of First Symptom (dd/mm/yy): ☐ ☐ ☐</td>
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</tbody>
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<tr>
<th><strong>B.2 PRE-EXISTING MEDICAL CONDITIONS</strong></th>
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</thead>
<tbody>
<tr>
<td>Diabetes ☐</td>
</tr>
<tr>
<td>Heart disease ☐</td>
</tr>
<tr>
<td>Chronic Lung disease ☐</td>
</tr>
<tr>
<td>Chronic Kidney Disease ☐</td>
</tr>
</tbody>
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<thead>
<tr>
<th><strong>B.3 HOSPITALIZATION DETAILS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalized: Yes ☐ No ☐</td>
</tr>
<tr>
<td>Hospitalization Date: ☐ ☐ ☐</td>
</tr>
<tr>
<td>Hospital Name:</td>
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<thead>
<tr>
<th><strong>TEST RESULT (To be filled by Covid-19 testing lab facility)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of sample receipt (dd/mm/yy)</td>
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