SRF ID (RTPCR): 3 3 7 2 9 0 1 2 2 4 5 9 9

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 to be filled

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: **DHARMADURAI**

Father's Name:

*Age: **29** Years

*Gender:Male ☑ Female ☐ Transgender ☐

*Occupation:**Other**

*Mobile Number: 7 6 3 9 7 6 5 9 3 6

*Mobile Number belongs to: Patient ☑ Family ☐

*Nationality: **India**

*Present patient address: **S-O AANDI**

*Downloaded Aarogya Setu App: Yes ☐ No ☑

ADIYANUR (V) KUNNUR (P) ATTUR (TK) SALEM (DT)

Pincode: - - - - - - **Rural**

*District : **SALEM**

*State : **TAMIL NADU**

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

Aadhaar No. (For Indians):

* Passport No. (for Foreign Nationals):

Received COVID-19 vaccine Yes ☑ No ☐

If yes type of vaccine **COVISHIELD - Serum Institute of India**

Date of Dose 1 : **24/03/2021** Dose 2 :**Yes** Date of Dose 2 : **30/06/2021**

*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)** ☐

*Collection date **25/02/2023**

*Sample ID(Label) **1**

If, RT-PCR test, name of lab where sample is sent for testing **GKMCHKTN - Government Kallakruichi Medical College and Hospital, Kallakurichi, Tamil Nadu**

* Mode of Transport used to visit testing facility

Symptomatic ☐ Asymptomatic ☑

Contact of a lab confirmed case : Yes ☐ No ☑

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

Not Applicable

***A.3.2 For Hospital**

Cat 7: Asymptomatic high risk patients who are hospitalized or seeking immediate hospitalization ☑

** 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	☐	Loss of taste	☐
Sore throat	☐	Diarrhoea	☐
Fever	☐	Breathlessness	☐
Loss of smell	☐	Other symptoms, please specify	

Date of onset of First Symptom :

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☑

Hospitalization Date:

Hospital State:

Hospital 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 the Authority(Lab in charge)