SRF ID (RTPCR): 3 3 5 8 5 0 0 5 9 0 2 9 5

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: **KANAKA**

Father's Name: **Boose**

*Age: **28** Years

*Gender:Male ☐ Female ☑ Transgender ☐

*Occupation:**Other**

*Mobile Number: 9 0 2 5 2 3 0 5 6 0

*Mobile Number belongs to: Patient ☑ Family ☐

*Nationality: **India**

*Present patient address: **NARIKKUDI ILAYANGUDI**

*Downloaded Aarogya Setu App: Yes ☐ No ☑

Pincode: - - - - - -

*District : **SIVAGANGA**

*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

Date of Dose 1 : Dose 2 :**No** Date of Dose 2 :

*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 **01/03/2022**

*Sample ID(Label) **2**

If, RT-PCR test, name of lab where sample is sent for testing **GSMCTN - Government Sivagangai Medical College, Sivaganga**

* 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 12: Testing on Demand ☑

** 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)