SRF ID (RTPCR): 3 3 5 6 9 0 0 6 1 8 0 5 8

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
- Field marked with asterisk(*) are mandatory

SECTION A – PATIENT DETAILS

A.1 TEST INITIATION DETAILS

*Doctor's Prescription : Yes ☑ No ☐
(If yes, attach prescription; if no, test cannot be conducted)

*Follow up Sample : Yes ☐ No ☑
If yes, Patient ID :

A.2 PERSON DETAILS

*Patient Name: **MANIKANDAN**
*Patient in quarantine facility: Yes ☐ No ☑
*Present Village or Town: **POLLACHI**
*District of present residence: **COIMBATORE**
*State of present residence: **TAMIL NADU**
*Patient's Present Address: **SO MARIAPPAN**
7 32 PASUMPON NAGAR KURUVIKULAM THENKASI DST
Pin Code:

*Age: **30** Years
*Gender:Male ☑ Female ☐ Others ☐
*Mobile Number: 9 5 7 8 6 4 3 5 9 7
*Mobile number belongs to: Self ☑ Family ☐
*Nationality: **India**
*Downloaded Aarogya Setu App: Yes ☐ No ☑
(These fields to be filled for all patients including foreigners)

Aadhaar No. (For Indians):
Passport No. (for Foreign Nationals):

*A.3 SPECIMEN INFORMATION FROM REFERRING AGENCY

*Specimen type	Throat Swab ☐	Nasal Swab ☑	BAL ☐	ETA ☐	Nasopharyngeal Swab ☐
*Collection date		**30/11/2020**			
*Sample ID(Label)		**4**			

*A.4 PATIENT CATEGORY (PLEASE SELECT ONLY ONE)

Cat-D17: Individual who wish to get tested

Section B- MEDICAL INFORMATION

B.1 CLINICAL SYMPTOMS AND SIGNS

Symptoms : Yes☐ No☑ If No please go to B.2 section

Symptoms	Yes	Symptoms	Yes	Symptoms	Yes	Symptoms	Yes	Symptoms	Yes
Cough	☐	Diarrhoea	☐	Vomiting	☐	Fever at evaluation	☐	Abdominal pain	☐
Breathlessness	☐	Nausea	☐	Haemoptysis	☐	Body ache	☐		
Sore throat	☐	Chest pain	☐	Nasal discharge	☐	Sputum	☐		

Which of the above mentioned was First Symptom: **.....** Date of onset of First Symptoms: **(dd/mm/yy)**

B.2 PRE-EXISTING MEDICAL CONDITIONS

Condition	Yes	Condition	Yes	Condition	Yes	Condition	Yes
Chronic lung disease	☐	Malignancy	☐	Heart disease	☐	Chronic liver disease	☐
Chronic renal disease	☐	Diabetes	☐	Hypertension	☐		

Immunocompromised condition: Yes☐ No☑ Other underlying conditions:

B.3 HOSPITALIZATION DETAILS

Hospitalized : Yes☐ No☑ Hospital State:
Hospital ID / Number: Hospital District:
Hospitalization Date: **(dd/mm/yy)** Hospital Name:

B.4 REFERRING DOCTOR DETAILS

Doctor's Email ID:
*Name of the Doctor: **JAYAKUMAR** Doctor's Mobile No.: **6369368089**

Lab where sample is sent: **ESICTN - Government Medical College and ESIC Hospital, Coimbatore, Tamil Nadu**

SRF ID Submit Date : **30/11/2020**

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)