

Date:

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

This form should be accompanied by a Prescription and a valid Govt ID

Client code:

Accession number:

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

* Doctor Prescription: Yes No

(If yes, attach prescription; If No, test cannot be conducted)

* Follow up Sample: Yes No

If Yes, Patient ID:

A.2 PERSONAL DETAILS

* Patient Name:

* Age: Years/Months age <1 yr, pls. tick months checkbox)

* Patient in quarantine facility: Yes No

* Gender: Male Female Others

* Present Village or Town:

* Mobile Number:

* District of Present Residence:

* Mobile Number belongs to: Self Family

* State of Present Residence:

* Nationality:

* Present patient address:

* Downloaded Aarogya Setu App: Yes No

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

Pincode:

Aadhar 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**

*** COLLECTION TIME**

* Sample ID (Label)

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

- Cat 1: Symptomatic international traveller in last 14 days.....
- Cat 2: Symptomatic contact of lab confirmed case.....
- Cat 3: Symptomatic Healthcare worker / Frontline workers
- Cat 4: Hospitalized SARI (Severe Acute Respiratory Illness) patient.....
- Cat 5a: Asymptomatic direct and high risk contact of lab confirmed case - family member
- Cat 5b: Asymptomatic healthcare worker in contact with confirmed case without adequate protection.....
- Cat 6: Symptomatic Influenza like Illness (ILI) in Hospital.....
- Cat 7: Pregnant woman in / near labour.....
- Cat 8: Symptomatic (ILI) among returnees and migrants (within 7 days of illness).....
- Cat 9: Symptomatic Influenza Like Illness(ILI) patient in Hotspot / Containment zones.....
- Other: (please specify) * (Select "other" only if the patient doesn't belong to category 1-8)

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	<input type="checkbox"/>	Diarrhoea	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	Fever at evaluation	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>
Breathlessness	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Haemoptysis	<input type="checkbox"/>	Body ache	<input type="checkbox"/>		
Sore throat	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	Nasal discharge	<input type="checkbox"/>	Sputum	<input type="checkbox"/>		

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

.....

B.2 PRE-EXISTING MEDICAL CONDITIONS

Condition	Yes	Condition	Yes	Condition	Yes	Condition	Yes
Chronic lung disease	<input type="checkbox"/>	Malignancy	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	Chronic liver disease	<input type="checkbox"/>
Chronic renal disease	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>		
Immunocompromised condition: YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	Other underlying conditions:			

B.3 HOSPITALIZATION DETAILS

Hospitalized: Yes No

Hospital ID / number:

Hospitalization Date: // (dd/mm/yy)

Hospital State:

Hospital District:

Hospital Name:

B.4 REFERRING DOCTOR DETAILS

*Name of Doctor:

Doctor Mobile No.:

Doctor Email ID:

* Fields marked with asterisk are mandatory to be filled. If collection date & collection time are not provided then sample will not be processed.

I have provided True and Reliable personal Information for COVID-19 Testing .

Patient Name _____
Patient Signature

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 Authority (Lab in charge)

To book an appointment  1800 222 000
or visit  srlworld.com

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