VIJAYA DIAGNOSTIC CENTRE®

India's Largest Comprehensive Diagnostic Network

ICMR No. VIJAY001
F/VDC/MSP/14-CTRF

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

*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: .....

*Patient in quarantine facility: Yes ☐ No ☐

*Present Village or Town: .....

*District of Present Residence: .....

*State of Present Residence: .....

*Present patient address: .....

.....

Pincode: ☐☐☐☐☐☐

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

*Gender: Male ☐ Female ☐ Other ☐

*Mobile Number: ☐☐☐☐☐☐☐☐☐☐

*Mobile Number belongs to: Self ☐ Family ☐

*Nationality: .....

*Downloaded Aarogya Setu App: Yes ☐ No ☐

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

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

*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) amongh 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) ☐

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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 symptom** ☐☐ ☐☐ ☐☐ **(dd/mm/yyyy)**

.....

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/yyyy)** **Hospital Name:** .....

B.4 REFERRING DOCTOR DETAILS

Doctor Mobile No.: .....

***Name of Doctor:** ..... **Doctor Email ID:** .....

** Fields marked with asterisk are mandatory to be filled*

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)