ICMR Specimen Referral Form for COVID-19 (SARS-CoV2) Version 9

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

contact@molq.in

SRF Generated on : 10:51 AM

SECTION A – PATIENT DETAILS		
A.1 TEST INITIATION DETAILS		
Doctor Prescription : Yes Status of clinical symptoms of patient : Asymptomatic	Is Repeat Sample: No Patient Id:	
A.2 PERSON DETAILS		
Patient Name : Vijay Kishan Murari	Age: 62 In Months:No	Gender:Male
Present Patient Village : Flat 1203, KSN Square, plot 12, 13 & 14, Vasundhara sector 3, Ghaziabad	Mobile Number : 9425005793	
District of present residence: Ghaziabad	Mobile Number Belongs to : Self	
State: Uttar Pradesh	Nationality: Indian	
Address: Flat 1203, KSN Square, plot 12, 13 & 14, Vasundhara sector 3, Ghaziabad	Patient Pincode: 201012	
Email: writetovkmurari@gmail.com	Aadhaar No: 656158946072	
Downloaded Aarogya Setu App: No	Passport (If Foreigner):	
A.3 SPECIMEN INFORMATION FROM REFERRING AGENCY		
Specimen Type: Nasal and Throat swab (Both)	Collection date: 2020-Feb-05	
Label: 10687934	Sample Collected by: Dharmendra	
A.4 Patient Category		
Others If Others: Pre hospitalization mandatory requirement		
A.5 STATUS OF CURRENT RESPIRATORY INFECTION		
Respiratory infection: Severe Acute Respiratory Illness (SARI): No		
Influenza Like Illness (ILI): No		
SECTION B- STATUS OF CURRENT RESPIRATORY INFECTION		

B.1 EXPOSURE HISTORY(2 WEEKS BEFORE THE ONSET OF SYMPTOMS)

Did you travel to foreign country in last 14 days? : No
Places of travel:

Have you been in contact with lab confirmed COVID-19 patient: No
If yes, name of confirmed patient:

Were you Quarantined?: No
If yes, where were you quarantined:

Are you a health care worker working in hospital involved in managing patients: No

B.2 CLINICAL SYMPTOMS AND SIGNS

Date of onset of symptoms:	First Symptom:

SYMPTOMS :

B.3 PRE-EXISTING MEDICAL CONDITIONS

Pre-existing medical conditions :

B.4 HOSPITALIZATION DETAILS

Hospitalized: No	Hospital State: Hospital District: Hospital Name::
Hospitalization Date:	

B.5 REFERRING DOCTOR DETAILS

Name of Doctor: Ashok Chaudhary	Doctor Mobile No.: 9953186205 Doctor Email ID: drashokdm@hotmail.com

TEST RESULT (To be filled by Covid-19 testing lab facility)

Date of sample receipt(dd/ mm/yy)	**Sample Id**	**Sample accepted/ Rejected**	**Date of Testing (dd/mm/yy)**	**Test result (Positive / Negative)**	**Repeat Sample required (Yes / No)**	**Sign of Authority (Lab in charge)**
						Dr. Jatinder Kaur

Attachments uploaded

- https://drive.google.com/open?id=1o5VbA2BwzImN-B34DUU6cTS_b4s_-4cH
- https://drive.google.com/open?id=1yY7weyZ0AlgKf6v-lUwx58UoNcF-PSrL, https://drive.google.com/open?id=1GRCTGDmUbphK0kOrQqT2sY2QMP_PtRCN

Ashok Chaudhary

MBBS
Registration Number: 48021
drashokdm@hotmail.com; 9953186205

Patient Name : Vijay Kishan Murari
Age: 62 [Is age is < 1 year: No] Gender:Male
Date:

Clinical Diagnosis: None

CLINICAL SYMPTOMS AND SIGNS	
Date of onset of symptoms:	First Symptom:
SYMPTOMS :	
PRE-EXISTING MEDICAL CONDITIONS	
Pre-existing medical conditions :	
HOSPITALIZATION DETAILS	
Hospitalized: No	Hospital State: Hospital District: Hospital Name::
Hospitalization Date:	

ADVICE - COVID-19 RTPCR Testing

Ashok Chaudhary
Registration Number: 48021

**Prescription template designed specially for covid-19 testing, with digital signature. Stamp not required*