POST GRADUATE DEPARTMENT OF MICROBIOLOGY
GOVERNMENT MEDICAL COLLEGE SRINAGAR
10-Karangar Srinagar Kashmir, 190010.

GOVT. ...
SR...

Receipt 2535
Date 28-5-21
Enclosures 1/4

-All HOD's
-All MS's
Kashmir 28/5/2021
PMC

Principal/Dean
Government Medical College,
Srinagar.

No. HOD/Micro/2021 728 Dated:-28 /05/2021

Subject:-ICMR Specimen Referral Form for COVID-19

Madam

As per new guidelines by ICMR Kindly find enclosed the new ICMR Specimen Referral Form which may be conveyed to all HOD"s & Medical Superintendent of associated hospitals Govt.Medical College Srinagar & accordingly the new ICMR specimen referral form shall be accepted by the department of Microbiology on wards.

Yours faithfully

Head of the Department.

Encl = 3 Nos

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

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:** ..... **Father's Name**.....

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

*** Gender: Male** ☐ **Female** ☐ **Transgender** ☐

***Occupation: Health Care Worker** ☐ **Police** ☐ **Sanitation** ☐ **Security Guards** ☐ **Others** ☐

***Mobile Number:** ☐☐☐☐☐☐☐☐☐☐ **Mobile Number belongs to: Patient** ☐ **Family** ☐

***Nationality:** .....

***Present patient address:** ..... ***Downloaded Aarogya Setu App: Yes** ☐ **No** ☐

..... **Pincode** .....

***District** ..... ***State:**.....

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

Aadhar No. (For Indians): .....

Passport No. (For Foreign Nationals): .....

***Received COVID-19 vaccine: Yes** ☐ **No** ☐

If yes type of vaccine: Covaxin ☐ **Covishield** ☐

Date of Dose 1 --/--/---- **Date of Dose 2** --/--/----

*A.3 SPECIMEN INFORMATION FROM REFERRING AGENCY

*Specimen type: Throat Swab ☐ Nasal Swab ☐ Bronchoalveolar lavage ☐ Endotracheal Aspirate ☐ Nasopharyngeal ☐

*Type of test: RT-PCR ☐ Rapid Antigen Test (RAT) ☐

*Name of kit used: ☐

*Collection date: ☐☐ ☐☐ ☐☐☐☐

*Sample ID (Label) ....

Symptomatic ☐ Asymptomatic ☐

Contact of a lab confirmed case: Yes ☐ No ☐

If, RT-PCR test, name of lab where sample is sent for testing (Drop down – list of Rt-PCR/ TrueNat/ CBNAAT labs)

* Mode of Transport used to visit testing facility
☐ Public – In drop down menu – Bus, Metro, Train, Cab, Auto, Ambulance
☐ Private – In drop down menu – Car, Scooty, Bike, Bicycle, Walk
☐ Not Applicable

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

Sample collected from
☐ Containment Zone
☐ Non-containment area
☐ Testing on demand
☐ Point of entry

Cat 1: All symptomatic (ILI symptoms) cases
Cat 2: All asymptomatic high-risk individuals (Any individual who falls under Section B2)
Cat 3: All symptomatic (ILI symptoms) individuals with history of international travel in the last 14 days
Cat 4: All individuals who wish to get themselves tested

A.3.2 For Hospital

Cat 1: All patients of Severe Acute Respiratory Infection (SARI)
Cat 2: All symptomatic (ILI symptoms) patients presenting in a healthcare setting
Cat 3: Asymptomatic high-risk patients who are hospitalized or seeking immediate hospitalization
Cat 4: Asymptomatic patients undergoing surgical / non-surgical invasive procedures (not to be tested more than once a week during hospital stay).
Cat 5: All pregnant women in/near labour who are hospitalized for delivery
Cat 6: All symptomatic neonates presenting with acute respiratory / sepsis like illness
Cat 7: Patients presenting with atypical manifestations [stroke, encephalitis, pulmonary embolism, acute coronary symptoms, Guillain Barre syndrome, Multi-system Inflammatory Syndrome in Children (MIS-C), progressive gastrointestinal symptoms] based on the discretion of the treating physician
Cat 8: All individuals who wish to get themselves tested

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(dd/mm/yy): ☐☐ ☐☐ ☐☐

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 Authority (Lab in charge)