



## 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**

\*Sample collected first time : Yes  No

If No, Patient ID :

**A.2 PERSONAL DETAILS**

\*Patient Name: **MR. SHAIKH ABDUL HASEEB ABDUL MABOOD** Father's Name:

\*Age: **35** Years

\*Gender: Male  Female  Transgender

\*Occupation: **Other**

\*Mobile Number: **9175770368**

\*Nationality: **India**

\*Present patient address: **E94 MIDC**

**RANJANGAON WALUJ ARNGABAD**

\*District : **AURANGABAD**

\*Mobile Number belongs to: Patient  Family

\*Downloaded Aarogya Setu App: Yes  No

Pincode: **- - - - -**

\*State : **MAHARASHTRA**

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

Aadhaar No. (For Indians): **636783893118**

\* Passport No. (for Foreign Nationals):

Received COVID-19 vaccine Yes  No

If yes type of vaccine

Date of Dose 1 :                      Dose 2 : **No**    Date of Dose 2 :

**\*A.3 SPECIMEN INFORMATION FROM REFERRING AGENCY**

\*Specimen type    Throat Swab     Nasal Swab     Bronchoalveolar lavage     Endotracheal Aspirate     Nasopharyngeal Swab

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

\*Collection date                      **22/07/2022**

\*Sample ID(Label)                      **10646056**

If, RT-PCR test, name of lab where sample is sent for testing

\* Mode of Transport used to visit testing facility

Symptomatic  Asymptomatic

Contact of a lab confirmed case : Yes  No

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

**Non-containment Zone**

**Cat 4: Testing on Demand**



**\*A.3.2 For Hospital**

Not Applicable

*\* 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	<input type="checkbox"/>	Loss of taste	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	Diarrhoea	<input type="checkbox"/>
Fever	<input type="checkbox"/>	Breathlessness	<input type="checkbox"/>
Loss of smell	<input type="checkbox"/>	Other symptoms, please specify	

Date of onset of First Symptom :

**B.2 PRE-EXISTING MEDICAL CONDITIONS**

Diabetes	<input type="checkbox"/>	Over weight/ Obesity	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>
Chronic lung disease	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
Chronic Kidney disease	<input type="checkbox"/>	Any other please specify	

**B.3 HOSPITALIZATION DETAILS**

Not Applicable

**Rapid Antigen Test**

Name of kit used

Date of Testing      Test result:

**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)





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 INDIAN COUNCIL OF  
 MEDICAL RESEARCH



SRF ID : 2746901352640 DD : DD15782 Sample Collection : 22/07/2022 10:25  
 Name : Mr. KADRI ABDUL SHAHED SADEK Age : 27 Yrs. Sex : M Sample Received : 22/07/2022 10:26  
 Ref. By : Self ICMR ID : 757116458 Report Released : 23/07/2022 16:41  
 Sent By : ENDURANCE TECHNOLOGIES LIMITED  
 Aadhar : 479396284317

### SARS-CoV2 (COVID-19) Rapid Antigen Test

Type of Sample : Nasopharyngeal swab  
 Method : Immunochromatography

Test Description	Result
SARS CoV2 Antigen Test	Antigen Negative

#### Test Interpretation

1. A **Positive** result indicates presence of SARS CoV2 Antigen in the specimen.
2. A **Negative** result indicates absence of SARS CoV2 Antigen in the specimen.

#### Note:

Apart from being faster, simpler and more specific, the test has a number of limitations:

- A negative result may occur if the level of antigen in the specimen is below the sensitivity of the test or if a poor quality specimen is obtained.
- Thus, a negative result does not eliminate the possibility of SARS CoV2 infection, and should be confirmed by molecular test for detection of SARS CoV 2 nucleic acid using Real Time PCR (RT-PCR) technology.

#### Associated tests:

COV19 : SARS CoV 2 RNA , PCR

(Collected At: 22/07/2022 10:25:25, Received At: 22/07/2022 10:25:55, Reported At: 23/07/2022 16:41:52)

----- End Of Report -----



Dr. Mayur Bhosale  
 (MD) Pathology

Dr. Shrikant B. Ovhar  
 (MD) Pathology

Dr. Santosh S. Tathe  
 (MD) Microbiology





SRF ID (Rapid Antigen): 2746901352642

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**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: **MR. HARUN YUNUS DESHMUKH**

Father's Name:

\*Age: **25** Years\*Gender: Male  Female  Transgender \*Occupation: **Other**

\*Mobile Number: 9623617316

\*Mobile Number belongs to: Patient  Family \*Nationality: **India**\*Present patient address: **E94 MIDC**\*Downloaded Aarogya Setu App: Yes  No **RANJANGAO WALUJ AURANGABAD**

Pincode: 431133

\*District : **AURANGABAD**\*State : **MAHARASHTRA**

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

Aadhaar No. (For Indians):

\* Passport No. (for Foreign Nationals):

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Date of Dose 1 : Dose 2 : **No** Date of Dose 2 :**\*A.3 SPECIMEN INFORMATION FROM REFERRING AGENCY**\*Specimen type Throat Swab  Nasal Swab  Bronchoalveolar lavage  Endotracheal Aspirate  Nasopharyngeal Swab \*Type of test **RT-PCR**  **Rapid Antigen Test (RAT)** \*Collection date **22/07/2022**\*Sample ID (Label) **10646053**

If, RT-PCR test, name of lab where sample is sent for testing

\* Mode of Transport used to visit testing facility

Symptomatic  Asymptomatic Contact of a lab confirmed case : Yes  No 

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 **Non-containment Zone****Cat 4: Testing on Demand**



**\*A.3.2 For Hospital**

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Section B3 needs to be filled only for Hospital settings

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