

# 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

<ul> <li>Seek guidance on requirements for the clinical specimen c</li> <li>This form may be filled in and shared with the IDSP and for</li> <li>Fields marked with asterisk(*) are mandatory to be filled</li> </ul>	warded to a lab where testing is planned
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 M. *Age: 35 Years  *Gender:Male Female Transgender *Occupation:Other  *Mobile Number: 9 1 7 5 7 7 0 3 6 8  *Nationality: India  *Present patient address: E94 MIDC  RANJANGAON WALUJ ARNGABAD  *District: AURANGABAD  (These fields to be filled for all patients including foreigners) Aadhaar No. (For Indians): 6 3 6 7 8 3 8 9 3 1 1  * Passport No. (for Foreign Nationals): Received COVID-19 vaccine Yes No Figure 1	*Mobile Number belongs to: Patient  Family  *Downloaded Aarogya Setu App: Yes  No  Pincode: *State: MAHARASHTRA
*A.3 SPECIMEN INFORMATION FROM REFERRING AC	GENCY
*Specimen type Throat Swab  Nasal Swab	Bronchoalveolar Endotracheal Nasopharyngeal Swab ☐ Aspirate ☐
*Type of test RT-PCR ☐ Rapid Antigen Test *Collection date 22/07/2022  *Sample ID(Label) 10646056  If, RT-PCR test, name of lab where sample is sent for testin * Mode of Transport used to visit testing facility Symptomatic ☐ Asymptomatic ☑ Contact of a lab confirmed case : Yes ☐ No ☑	ng
Please Note - Hospital form is required for the patients vis under containment zone/ Non-containment area/ Point of e	siting OPD, IPD and Emergency and Community form is required for patients entry/ Testing on demand
under containment zone/ NorPcontamment areas / ***********************************	A.3.1 For Community
Sample collected from	Non-containment Zone

*A.3.2 For Hospital
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### 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 illied only for Hospital se	ungs	The state of the s		
S	ection B- MEI	DICAL INFORMATION		
B.1 CLINICAL SYMPTOMS AND SIGNS				
Cough	Г	Loss of taste		T
Sore throat		Diarrhoea		
Fever		Breathlessness		
Loss of smell	<b>T</b>	Other symptoms, please specify		
Date of onset of First Symptom :				
B.2 PRE-EXISTING MEDICAL CONDITIONS				
Diabetes		Over weight/ Obesity	-	
Heart disease		Hypertension		
Chronic lung disease	Г	Cancer		
Chronic Kidney disease		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)	Date of testing (dd/mm/yy)	1 5 5 5 1 5 5 5 5 6 5 6 6 6 6 6 6 6 6 6	required (Yes/No)	Sign of the Authority(Lab in charge)



DIAGNOSTICS

Administr Parassey & Monthine gy Lac HUNESTY / HITSGREY (UNIVERSELY A UNIT OF MERAPH HEAZHICARE SERVICES PVS. LID. Shop No 12,13, Disha Sankut, Nese Refiance Mall, Garkheda, Aurangabad - 431009 Contact No. - 9872965747 , 925896946 Land Sine No. - 0240 2565247

I mail: detectdiagnostics@gmail.com Website: www.detectdiagnostics.com



NABL Accredited





SRF ID: 2746901352640

Name : Mr. KADRI ABDUL SHAHED SADEK

Ref. By : Self

Sent By: ENDURANCE TECHNOLOGIES LIMITED

DD: DD15782

Age : 27 Yrs. Sex : M

ICMR ID: 757116458

Aadhar: 479396284317

Sample Collection: 22/07/2022 10:25

Sample Received: 22/07/2022 10:26

Report Released : 23/07/2022 16:41

SARS-CoV2 (COVID-19) Rapid Antigen Test

Type of Sample

Method

Nasopharyngeal swab

: 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 addicates absence of SARS CoV2 Anagem in the specimen.

Note:

Apart from being faster, simpler and more specific, the fast 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 nucleis acid using Real Time PCR (RT-PCR) technology.

Associated tests.

COVID: SARS COVIDENA, POR

(Collected At. 22.07-2022 10:28:25, Received At. 22.07/2022 10:25:35, Reported At. 23.07/2022 16:47:52)

- End Of Report



(13) land

Dr. Mayur Bhosale (MD) Pathology 83)m.

Dr. Shrikant B. Ovhar (MD) Pathology

Holle

Dr. Santosh S. Tathe (MD) Microbiology

Note: Please keep this document confidential. Do

not chare this link with anyone



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SECTION A - PATIENT DETAILS	
A.1 TEST INITIATION DETAILS	
*Sample collected first time : Yes   No   No   No   No   No   No   No   N	
A.2 PERSONAL DETAILS	
*Patient Name: MR. HARUN YUNUS DESHMUKH *Age: 25 Years *Gender:Male ✓ Female ☐ Transgender ☐ *Occupation:Other	Father's Name:
*Mobile Number: 9623617316  *Nationality: India	*Mobile Number belongs to: Patient <b>▽</b> Family <b>□</b>
*Present patient address: E94 MIDC  RANJANGAO WALUJ AURANGABAD  *District: AURANGABAD	*Downloaded Aarogya Setu App: Yes No Pincode: 431133 *State: MAHARASHTRA
(These fields to be filled for all patients including foreigners) Aadhaar No. (For Indians):  * Passport No. (for Foreign Nationals):	otate: Wallace et al.
Received COVID-19 vaccine Yes ☐ No ☑  If yes type of vaccine  Date of Dose 1 : Dose 2 : No Date of Dose 2 :	
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*Specimen type Throat Swah Nasal Swah	ge 🗆 Aspirate 🖂 Nasopharyngeal Swab 🖂
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Contact of a lab confirmed case : Yes ☐ No 🔽	
Please Note - Hospital form is required for the patients visiting OPI under containment zone/ Non-containment area/ Point of entry/ Test	D, IPD and Emergency and Community form is required for patients ting on demand
	r Community
Sample collected from N	on-containment Zone

Cat 4: Testing on Demand ♥

*A.3.2 For F	<b>Hospital</b>	
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Cough Sore throat Fever Loss of smell Date of onset of First Symptom:		Loss of taste Diarrhoea Breathlessness Other symptoms, please specify		
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Diabetes Heart disease Chronic lung disease Chronic Kidney disease		Over weight/ Obesity Hypertension Cancer 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)