Lifeline LABORATORY

ICMR Registration No - LLNDD001

Address: H-11 Green Park Extension New Delhi

Call us: 011-49575700

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

This form should be accomplained by a prescription and a valid govt. Id.

INSTRUCTIONS:

- 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)

***Repeat Sample:** Yes ☐ No ☐
If Yes, Patient ID: ……

A.2 PERSONAL DETAILS

***Patient Name:** ……

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

***Present Village or Town:** ……..……..

***Gender:** Male ☐ Female ☐ Others ☐

***District of Present Residence:**……

***Mobile Number:** ☐☐☐☐☐☐☐☐☐☐

***State of Present Residence:**……

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

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

***Nationality:** ……..

Present patient address: ……...

……

Pincode: ☐☐☐☐☐☐

Email: ……

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

Aadhar No. (For Indians):

☐☐☐☐☐☐☐☐☐☐☐☐

***Downloaded Aarogya Setu App:** Yes ☐ No ☐

Patient in quarantine facility: Yes ☐ No ☐

*A.3 SPECIMEN INFORMATION FROM REFERRING AGENCY

***Specimen type:** Throat Swab ☐ Nasal Swab ☐ BAL ☐ ETA ☐ Nasopharyngeal swab ☐

***Collection date**

***Label**

*A.4 PATIENT CATEGORY (PLEASE SELECT ONLY ONE)

A. Routine surveillance in containment zones and screening at points of entry:

Category 1: All symptomatic (ILI symptoms) cases including health care workers and frontline workers. ☐

Category 2: All asymptomatic direct and high-risk contacts (in family and workplace, elderly ⩾ 65 years of age, immunocompromised, those with co-morbidities etc.) of a laboratory confirmed case to be tested once between day 5 and day 10 of coming into contact. ☐

Category 3: All asymptomatic high-risk individuals (elderly ⩾ 65 years of age, those with co-morbidities etc.) in containment zones. ☐

B. Routine surveillance in non-containment areas:

Category 4: All symptomatic (ILI symptoms) individuals with history of international travel in the last 14 days. ☐

Category 5: All symptomatic (ILI symptoms) contacts of a laboratory confirmed case. ☐

Category 6: All symptomatic (ILI symptoms) health care workers / frontline workers involved in containment and mitigation activities. ☐

Category 7: All symptomatic ILI cases among returnees and migrants within 7 days of illness. ☐

Category 8: All asymptomatic high-risk contacts (contacts in family and workplace, elderly ⩾ 65 years of age, those with co-morbidities etc. ☐

C. In Hospital Settings:

Category 9: All patients of Severe Acute Respiratory Infection (SARI). ☐

Category 10: All symptomatic (ILI symptoms) patients presenting in a healthcare setting. ☐

Category 11: Asymptomatic high-risk patients who are hospitalized or seeking immediate hospitalization such as immunocompromised individuals, patients diagnosed with malignant disease, transplant patients, patients with chronic co-morbidities, elderly ⩾ 65 years. ☐

Category 12: Asymptomatic patients undergoing surgical / non-surgical invasive procedures (not to be tested more than once a week during hospital stay). ☐

Category 13: All pregnant women in/near labour who are hospitalized for delivery. ☐

Category 14: All symptomatic neonates presenting with acute respiratory / sepsis like illness. ☐

Category 15: Patients presenting with atypical manifestations. ☐

D. Testing on demand (State Governments to decide simplified modalities):

Category 16: All individuals undertaking travel to countries/Indian states mandating a negative COVID-19 test at point of entry. ☐

Category 17: All individuals who wish to get themselves tested. ☐

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 symptoms:** ☐☐ / ☐☐ / ☐☐

……..……..……..……

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, TREATMENT AND INVESTIGATION

Hospitalized: Yes ☐ **No** ☐ **Hospital State:** ……

Hospital ID / number: ..... **Hospital District:** ……

Hospitalization Date ☐☐ / ☐☐ / ☐☐ **(dd/mm/yy)** **Hospital Name:** ……

B.4 REFERRING DOCTOR DETAILS

***Name of Doctor:** ……..... **Doctor Mobile No.:** ……

Doctor Email ID: ……

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

I have read and understood the form. The above details given by me are true to my knowledge

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 incharge)