SCIENTIFIC® PATHOLOGY

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0562 42-55-555

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Doc No. SP / SERO / FR / 10
Issue 1, Rev: 00 Dated: 23 04 2020

SAMPLE REQUISITION FORM FOR 2019-nCoV (SARS-CoV-2) TESTING

THIS FORM SHOULD BE ACCOMPANIED BY A PRESCRIPTION AND A VALID GOVT ID.

INTRODUCTION

This form is forcollection 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

***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:** .....

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

***District of Present Residence:**.....

***State of Present Residence:**.....

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

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

***Gender: Male ☐ Female ☐ Others ☐**

***Mobile Number:** ☐☐☐☐☐☐☐☐☐☐

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

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

Present patient address: .....

.....

Pincode: ☐☐☐☐☐☐

Email: .....

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

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

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

*A.3 SPECIMEN INFORMATION FROM REFERRING AGENCY

*Specimen type	BAL/ETA ☐	TS/NPS/NS ☐	Blood in EDTA ☐	Acute sera ☐	Covalescent sera ☐	Other ☐
*Collection date						
*Label						

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

Cat 1: Symptomatic international traveller in last 14 days..... ☐
Cat 2: Symptomatic contact of lab confirmed case..... ☐
Cat 3: Symptomatic healthcare worker..... ☐
Cat 4: Hospitalized SARI (Severe Acute Respiratory Illness) patient..... ☐
Cat 5a: Asymptomatic direct and high risk contact of lab confirmed case ..... ☐
Cat 5b: Asymptomatic healthcare worker in contact with confirmed case without adequate protection... ☐
Cat 6: Symptomatic Influenza Like Illness (ILI) patient in hospital/ MoHFW identified clusters..... ☐
Cat 7a: Tablighi jamaat..... ☐
Cat 7b: Tablighi jamaat Contacts ..... ☐
Others..... ☐

(Please select "others" only if the patient doesn't fall in any other category)

*A.5 STATUS OF CURRENT RESPIRATORY INFECTION

* **Respiratory infection:** Severe Acute Respiratory Illness (SARI): Yes ☐ No ☐ , Influenza Like Illness (ILI): Yes ☐ No ☐

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SECTION B- MEDICAL INFORMATION

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

1. Did you travel to foreign country in last 14 days: ☐ Yes ☐ No

If yes, place(s) of travel: ....., Stay/travel duration: ☐☐/☐☐/☐☐ to ☐☐/☐☐/☐☐ (dd/mm/yy)

2. Have you been in contact with lab confirmed COVID-19 patient: Yes ☐ No ☐

If yes, name of confirmed patient: .....

3. *Were you Quarantined?: Yes ☐ No ☐ *If yes, where were you quarantined: Home ☐ Facility ☐

4. Are you a health care worker working in hospital involved in managing patients: ☐ Yes ☐ No

B.2 CLINICAL SYMPTOMS AND SIGNS

Date of onset of symptoms: ☐☐/☐☐/☐☐ (dd/mm/yy) First Symptom: .....

Symptoms	Yes	Symptoms	Yes	Symptoms	Yes	Symptoms	Yes	From (dd/mm)	To (dd/mm)
Cough	☐	Diarrhoea	☐	Vomiting	☐	Fever atevaluation	☐ if yes,	☐☐/☐☐	☐☐/☐☐
Breathlessness	☐	Nausea	☐	Haemoptysis	☐	Body ache	☐ if yes,	☐☐/☐☐	☐☐/☐☐
Sore throat	☐	Chest pain	☐	Nasal discharge	☐				
Sputum	☐	Abdominal pain	☐						

(HISTORY)

B.3 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.4 HOSPITALIZATION DETAILS

Hospitalized: Yes ☐ No ☐

Hospital State: .....

Hospital District: .....

Hospitalization Date: ..... (dd/mm/yy)

Hospital Name: .....

B.5 REFERRING DOCTOR DETAILS

Doctor Mobile No.: .....

*Name of Doctor: .....

Doctor Email ID: .....

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

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)