



**\*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 <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(dd/mm/yy): <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
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			
Hospitalized: Yes <input type="checkbox"/> No <input type="checkbox"/>		Hospital State: _____	
		..... <b>Hospital</b>	
Hospitalization Date: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		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)