DDRC SRL
Diagnostic Services
INDIA'S LEADING DIAGNOSTICS NET WORK

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ICMR REG.NO: DDRCE001

COVID TEST REQUISITION FORM

Date: ……………………….

Test Requested: (A) RT PCR ☐ (B) RAPID ANTIGEN ☐

Name :……………………………………………………………………… **Age:** …………… **Sex:** ……………..

Nationality :……………………………………………….. **Arogyasethu installed:** Yes ☐ No ☐

E mail id :……………………………………………………………………. **Contact No:** ☐☐☐☐☐☐☐☐☐☐

(A) Permanent Address: …………………………………… **(B) Local Address (if different):** ………………………………….

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Pincode: ………………………………… **State:** ………………………………… **District:** …………………………………………

Name of Local body: ……………………………………………………………………

Local body type: (A) Grama Panchayat ☐ (B) Municipality ☐ (C) Corporation ☐

ID proof detail (tick): Aadhar card / Passport /others ……………………… No ☐☐☐☐☐☐☐☐☐☐☐☐

Date of arrival in India: …………………………………………………………………

Any travel domestic/international in the last 14 days : Yes ☐ No ☐

If yes, specify the details (place & date etc.): ………………………………………………………………………………………………………

Patient under quarantine: Yes ☐ No ☐ **Sample type:** Nasopharyngeal ☐

Time of Sample Collection: ……………………………… Oropharyngeal ☐ Others ☐

Patient Status: (A) Symptomatic ☐ (B) Asymptomatic ☐

History of any other disease: *(specify)* ………………………………………………………………………………………………

If symptomatic: *(specify)* ………

Referred by: (A) Self ☐ (B) Doctor ☐ (C) Hospital ☐

Details of referral:

(A) Name of Doctor: …………………………………………………… (B) Mob No: ……………………………………………………

(C) Email id: ………………………………………… (D) Name of Hospital: ………………………………………………………………

(E) Hospitalized: Yes ☐ No ☐ (F) Date of onset of symptoms: ………………………………………………

PREVIOUS COVID TESTING DETAILS:

Have you tested for Covid in last 10 days? Yes ☐ *No* ☐ *If yes, date of testing:* ………………………………

Test: RAPID ANTIGEN ☐ *RT PCR* ☐ *TRUNAT* ☐ *Result: Negative* ☐ *Positive* ☐

Centre of Testing: ………

Category:

Cat 1: All symptomatic (ILI symptoms) cases including health care workers and frontline workers………………………………………………………. ☐
Cat 2: All asymptomatic direct and high-risk contacts (contacts in family and workplace, elderly ≥ 65 years of age, those with co-morbidities etc.) ☐
Cat 3: All asymptomatic high-risk individuals……….. ☐
Cat 4: All symptomatic (ILI symptoms) individuals with history of international travel in the last 14 days………………………………………………. ☐
Cat 5: All symptomatic (ILI symptoms) contacts of a laboratory confirmed case…………………………………………………………………………….. ☐
Cat 6: All symptomatic (ILI symptoms) health care workers / frontline workers involved in containment and mitigation activities…………………….. ☐
Cat 7: All symptomatic ILI cases among returnees and migrants within 7 days of illness……………………………………………………………….. ☐
Cat 8: All asymptomatic high-risk contacts (contacts in family and workplace, elderly ≥ 65 years of age, those with co-morbidities etc.) …………. ☐
Cat 9: All patients of Severe Acute Respiratory Infection (SARI)………………………………………………………………………………………. ☐
Cat 10: All symptomatic (ILI symptoms) patients presenting in a health care setting…………………………………………………………………. ☐
Cat 11: Asymptomatic high-risk patients who are hospitalized or seeking immediate hospitalization………………………………………………. ☐
Cat 12: Asymptomatic patients undergoing surgical/non-surgical invasive procedures (not to be tested more than once a week during hospital stay) ☐
Cat 13: All pregnant women in/near labour who are hospitalized for delivery…………………………………………………………………………….. ☐
Cat 14: All symptomatic neonates presenting with acute respiratory / sepsis like illness………………………………………………………………….. ☐
Cat 15: Patients presenting with atypical manifestations (stroke, pulmonary embolism, acute coronary symptoms etc) based of the discretion of the treating physician …… ☐
Cat 16: All individuals undertaking travel to countries/Indian states mandating a negative Covid-19 test at point of entry……………………………. ☐
Cat 17: All individuals who wish to get themselves tested……………………………………………………………………………………………….. ☐

INFORMED CONSENT FOR SELF REFERRED PATIENTS

I, ………………………………………………………………………………..….. have been informed by ……………………………………………………….. about the nature of Covid 19, various tests available and the follow up action required.

I am willing to abide by the recommendations and guidelines issued by the department of health and family welfare, Govt of Kerala. If tested positive I shall contact Disha (helpline number 1056) or consult my referring physician and undergo isolation or admission in CFLTC/Covid hospital/Private hospital.

Name of person undergoing test: …………………………………………………………………………………………….…………

Signature ……………………………… Date……………….…………………………

Name of lab technologist: ……………………..

Signature ……………………………… Date……………….…………………………

വോക്ഇൻ കോവിഡ് 19 ടെസ്റ്റിനുള്ള അറിയിപ്പും സമ്മതപത്രവും

ഞാൻ, ………………………………………………… കോവിഡ് 19 രോഗത്തിന്റെ സ്വഭാവത്തെകുറിച്ചും അതിന് ലഭ്യമായ വിവിധ പരിശോധനകളെകുറിച്ചും തുടർ നടപടികളെകുറിച്ചും ……………… ………………………………………………… അറിയിച്ചിട്ടുണ്ട്.

ഞാൻ കേരള സർക്കാരിന്റെ ആരോഗ്യ കുടുംബക്ഷേമ വകുപ്പ് പുറപ്പെടുവിച്ചിട്ടുള്ള ശുപാർശകളും മാർഗ്ഗ നിർദ്ദേശങ്ങളും പാലിക്കാൻ തയ്യാറാണ്. പോസിറ്റീവാണെന്ന് പരിശോധനഫലം ലഭിച്ചാൽ ഞാൻ ദിശയുമായി(ഹെൽപ്പ് ലൈൻനമ്പർ 1056) ബന്ധപ്പെടുകയോ എന്റെ റഫറിങ് ഡോക്ടറിനെസമീപിക്കുകയോ സി. എഫ്.എൽ .ടി.സി./ കോവിഡ് ആശുപത്രി / സ്വകാര്യ ആശുപത്രി അല്ലെങ്കിൽ സ്വയം ഐസുലേഷനിൽ പ്രവേശിക്കുകയോ ചെയ്യും.

ടെസ്റ്റിനു വിധേയമായ വ്യക്തിയുടെ പേര് ……………………………………………

ഒപ്പ്……………………………………തീയതി……………………………………

ലാബ് ടെക്നോളജിസ്റ്റ് ……………………………………………

ഒപ്പ്……………………………………തീയതി……………………………………