XCyton

(NABL Certificate No.: MC2399)
(ICMR Reg No. XCDPLB)

XCyton Diagnostics Pvt. Ltd, #449, 10th cross, 4th phase,
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COVID-19 (SARS-CoV2) RT-PCR test (MGX035)

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
- 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 :** .....

***Present patient address:** ... ...

.....

***Pincode:** ☐☐☐☐☐☐

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

***Gender:** Male ☐ Female ☐ Others ☐

***Mobile Number :** ☐☐☐☐☐☐☐☐☐☐

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

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

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

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

Email: .....

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

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

*A.3 SPECIMEN INFORMATION FROM REFERRING AGENCY

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

***Collection date**

***Sample ID (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..... ☐

Other:..... ..... ☐

(Please select "other" 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: ..... ,

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	Symptoms	Yes
Cough	☐	Diarrhoea	☐	Vomiting	☐	Fever at evaluation	☐	Abdominal pain	☐
Breathlessness	☐	Nausea	☐	Haemoptysis	☐	Body ache	☐		
Sore throat	☐	Chest pain	☐	Nasal discharge	☐	Sputum	☐		

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 conditio n: 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

*Name of Doctor: ..... Doctor Email ID: .....

Doctor Mobile No.: ..... Doctor Signature: .....

B.6 PATIENT / GUARDIAN DETAILS

Patient / guardian name ..... Patient / guardian Signature .....

** 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)