**Date:**      **Reference Number:**

**Patient’s Detail**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient’s Name: |  | | | |
| Patient’s Age: |  | | Sex: |  |
| Patient’s Temporary Address | Province: | | District: | |
| Municipality: | | Ward: | |
| Patient’s Permanent Address | Province: | | District: | |
| Municipality: | | Ward: | |
| Patient’s contact detail | Landline: | Mobile: | | Email: |
| Name of hospital where patient is admitted |  | | | |
| Patient’s Hospital ID |  | | | |

**Travel and Contact History**

|  |  |
| --- | --- |
| Details |  |
| Travelled in last 28 days to the community which has detection of case |  |
| Anyone from the family or close contact travelled last 28 days to the community which has detection of case |  |
| History of close contact with COVID19 positive patient |  |
| Health care worker taking care of COVID19 positive patient |  |

**Symptoms**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Fever |  | Myalgia |  | Rhinorrhea |  | Anosmia |  |
| Cough |  | SOB |  | Sore throat |  | Diarrhea |  |

**Comorbid conditions**

|  |
| --- |
|  |

**Clinical condition:**

**Radiological/Test result**

|  |  |  |
| --- | --- | --- |
| Chest X ray | CT Chest | RDT |

**Type of sample collected for RT-PCR**

|  |  |  |  |
| --- | --- | --- | --- |
| Nasopharyngeal | Oropharyngeal (Throat) | Endotracheal Aspirate | Bronchialveolar |

**Transportation**

|  |  |  |
| --- | --- | --- |
| Sample in VTM | Triple layer packaging done | Cold chain maintained |

**Information**

|  |
| --- |
| Sample must reach Patan Hospital, PCR lab by 10 am  Reports will be made available after 12-24 hours  This form needs to be filled mandatory by clinician to send sample for COVID19 test  Sample from the patient not meeting the criteria of suspect and not in isolation facility won’t be accepted for COVID19 testing  Sample should be collected and transported in VTM in triple layer packaging and maintaining cold chain  As all testing are reported to government authority, above mentioned details need to be verified by authorized person of hospital  Please send this form electronically to [pcrlab@pahs.edu.np](mailto:pcrlab@pahs.edu.np)  EDCD patient detail form is also required to fill up and sent to [ewarsedcd@gmail.co](mailto:ewarsedcd@gmail.co) and [pcrlab@pahs.edu.np](mailto:pcrlab@pahs.edu.np) |

|  |  |
| --- | --- |
| **Focal person for COVID19**  Name:  Position:  Signature:  Phone number:  Email address: | **Attending Doctor**  Name:  Position:  Signature:  Phone number:  Email address: |