Instructions for Collection, Packaging, Labeling and Transport of Specimens from Designated Government and Private Hospitals for COVID-19 Testing at ILBS

➢ Institute of Liver and Biliary Sciences, a super specialty NABH and NABL accredited hospital has been designated as COVID-19 testing laboratory by ICMR/GOI

➢ Accordingly, samples are currently being accepted only from such designated government and private hospitals for the purpose of COVID-19 testing.

➢ The following guidelines should be adhered to by the referring hospitals regarding collection, storage, packaging and transport of these samples.

A. Patient selection
   a. The patient selection for the COVID-19 testing should be in accordance with the ICMR guidelines (updated version time to time) (to be downloaded from https://www.icmr.nic.in/content/covid-19)
   b. Demographic and clinical details of selected patients are to be filled in the “SPECIMEN REFERRAL FORM” as per Annexure A of this document
   c. The specimen referral form is to be signed by the treating clinician of the hospital and countersigned by the Medical Superintendent / Admin Authority of the hospital.
   d. Each sample is to be accompanied by a completely filled Sample Referral Form, however, multiple such samples can be accommodated in the same outer packaging (details below)
   e. Each package must be accompanied by a “COVERING LETTER” as per Annexure B of this document.

B. Sample Collection
   a. TYPE OF SPECIMEN - NASOPHARYNGEAL SWAB AND THROAT SWAB
   b. Collecting / referring hospital can formulate their own guidelines for collecting of specimens in accordance with standard SOPs issued by WHO/ICMR/NCDC etc for this purpose

C. Sample Packaging
   a. Packaging of samples should adhere to ICMR guidelines available on https://www.mohfw.gov.in/pdf/5Sample%20collection_packaging%20%202019-nCoV.pdf
   b. Collected samples should be placed immediately into Viral Transport Medium (VTM), and the neck of VTM should be sealed with parafilm (refer to above Guidelines)
   c. Properly label the VTM Vial ( name, age, gender, hospital name)
   d. Cover the VTM vial with absorbent material (cotton/tissue paper)
e. VTM vial should be placed in a secondary container which has a screw cap and the screw cap to be tightened properly.

f. Arrange the VTM vial (primary container) into secondary container i.e 50 ml centrifuge tube/ any screw capped plastic tube. SCREW THE CAP SECURELY.

g. Place the secondary container into a zip lock pouch. Wipe the zip lock pouch with freshly prepared 1% sodium hypochloride.

h. Place the zip lock pouch into sturdy plastic container and seal neck of the container, OR, if sturdy plastic container is not available, place the above zip lock pouch into another zip lock pouch.

i. Place the above packed material into a suitable outer container (thermocol box/ice box/hard board box) surrounded by hard frozen gel packs.

Place the SPECIMEN REFERRAL FORMS and COVERING LETTER in a ZIP LOCK POUCH. Secure this ZIP LOCK POUCH on the outside of the package for easy retrieval. DO NOT PLACE COVERING LETTER/ SPECIMEN REFERRAL FORM INSIDE THE PACKAGING

LABELLING

- Biohazard symbol
- Orientation Label
- Handle with Care Sign
- Print “Category B” on the outside
- UN 3373 symbol
- Name of Sending Hospital clearly in bold letters, Name and contact number of Nodal Officer of the hospital

Attach the labels properly

IMPROPERLY PACKED AND / OR LABELLED PACKAGES MAY BE REJECTED

Send box along with above mentioned documents to:

COVID-19 SAMPLE RECEIVING AREA
WHO Collaborating Center
(Behind APJ Abdul Kalam Auditorium)
Ground Floor, Phase 2 Building
Institute of Liver and Biliary Sciences
D1, Vasant Kunj, New Delhi - 110070

Ask the delivery person to enter from Gate No 5 of ILBS

Handover all the contents to the designated person.

Please inform the contact person (Dr Shantanu Dubey 9540947021 or Dr Abhishek Padhi 9938499139 or COVID helpline number 011-46300068) before sending the specimen.

SAMPLE RECEIVING TIME AT ILBS: 24 x 7 (round the clock)

Note: All the reports will be communicated to the nodal officers by email. Physical reports can be collected from the Sample Collection Area from 9:00 AM to 5:00 PM the next day.
ICMR Specimen Referral Form for COVID-19 (SARS-CoV2)

**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: .................................................................

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

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

*Gender: Male [ ] Female [ ] Others [ ]

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

*Mobile Number: .............................................................

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

*Mobile Number belongs to: Self [ ] Family [ ]

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

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

*Pincode: [ ] [ ] [ ] [ ] [ ] [ ]
(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 [ ] Covalent 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[ ]
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: ........................................

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Yes</th>
<th>Symptoms</th>
<th>Yes</th>
<th>Symptoms</th>
<th>Yes</th>
<th>Symptoms</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cough</td>
<td>☐</td>
<td>Diarrhoea</td>
<td>☐</td>
<td>Vomiting</td>
<td>☐</td>
<td>Fever at evaluation</td>
<td>☐</td>
</tr>
<tr>
<td>Breathlessness</td>
<td>☐</td>
<td>Nausea</td>
<td>☐</td>
<td>Haemoptysis</td>
<td>☐</td>
<td>Body ache</td>
<td>☐</td>
</tr>
<tr>
<td>Sore throat</td>
<td>☐</td>
<td>Chest pain</td>
<td>☐</td>
<td>Nasal discharge</td>
<td>☐</td>
<td>Sputum</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B.3 PRE-EXISTING MEDICAL CONDITIONS

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>Condition</th>
<th>Yes</th>
<th>Condition</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic lung disease</td>
<td>☐</td>
<td>Malignancy</td>
<td>☐</td>
<td>Heart disease</td>
<td>☐</td>
</tr>
<tr>
<td>Chronic renal disease</td>
<td>☐</td>
<td>Diabetes</td>
<td>☐</td>
<td>Hypertension</td>
<td>☐</td>
</tr>
<tr>
<td>Immunocompromised condition</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td>Other underlying conditions:</td>
<td></td>
</tr>
</tbody>
</table>

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 Mobile No.: .....................................
Doctor Email ID: .......................................  

* Fields marked with asterisk are mandatory to be filled

TEST RESULT (To be filled by Covid-19 testing lab facility)

<table>
<thead>
<tr>
<th>Date of sample receipt (dd/mm/yy)</th>
<th>Sample accepted/Rejected</th>
<th>Date of Testing (dd/mm/yy)</th>
<th>Test result (Positive / Negative)</th>
<th>Repeat Sample required (Yes / No)</th>
<th>Sign of Authority (Lab in charge)</th>
</tr>
</thead>
</table>
Annexure B
(Covering letter)

To,

The Nodal Officer,
COVID-19 Testing Centre,
ILBS, New Delhi

Dear Sir/Madam,

A total of .......... specimens Dated.............. are being sent from hospital .................................................for the purpose of COVID-19 testing at your centre. We confirm that the samples have been packed and transported under proper biosafety precautions.

Treating physician in charge  Medical superintendent

Signature  Signature
Name  Name
Date  Date
Stamp  Stamp