औषधि विभाग
श्री कृष्ण चिकित्सा महाविद्यालय अस्पताल
मुजफ्फरपुर।

आदेश

सभी संबंधित चिकित्सकों को यह आदेश दिया जाता है कि कोरोना वाईरस से संदिग्ध मरीज के आने पर ओ0पी0डी0 / ईमरजेन्सी पी0ओ0डी0 उसके प्राथमिकता के आधार पर देखकर उसका संबंधित जॉच कराने की व्यवस्था करेंगे तथा कारोना नोडल पदाधिकारी को सूचित करेंगे।

ह0 / –
विभागाध्यक्ष
औषधि विभाग
श्री कृष्ण चिकित्सा महाविद्यालय अस्पताल,
मुजफ्फरपुर।

ज्ञापांक 109 / मुजफ्फरपुर, दिनांक 18/02/2020 /

प्रतिलिपिः– प्राचार्य, श्री कृष्ण चिकित्सा महाविद्यालय, मुजफ्फरपुर को सूचनार्थ प्रेषित।

प्रतिलिपिः– माईक्रोबॉयलोजी विभाग, श्री कृष्ण चिकित्सा महाविद्यालय, मुजफ्फरपुर को सूचनार्थ प्रेषित।

प्रतिलिपिः– अधीक्षक, श्री कृष्ण चिकित्सा महाविद्यालय अस्पताल, मुजफ्फरपुर को सूचनार्थ प्रेषित।

प्रतिलिपिः– संबंधित सभी चिकित्सक, औषधि विभाग, श्री कृष्ण चिकित्सा महाविद्यालय अस्पताल, मुजफ्फरपुर को सूचनार्थ प्रेषित।

संलग्न :- गाइडलाइन कि छाया प्रति।

18/2/2020
विभागाध्यक्ष
औषधि विभाग
श्री कृष्ण चिकित्सा महाविद्यालय अस्पताल,
मुजफ्फरपुर।

Sri Krishan Medical College, Muz.
Letter No:- 668/20
Date:- 18/02/2020
Receiver Sign

ICMR- National Institute of Virology, Pune
Specimen Referral Form for 2019 Novel Coronavirus (2019-nCoV)

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 also ICMR-NIV nodal officer in advance.*

PERSON DETAILS

Name of patient: .....
Address: .....
City: .....
State: .....

Age:.....Years.....Month Gender: Male Female

Date of birth: ...../...../..... (dd/mm/yyyy)

Mobile/phone: _____

Email: _____

EXPOSURE HISTORY (2 WEEKS BEFORE THE ONSET OF SYMPTOMS)

Recent stay/travel in area (Wuhan, China): Yes No If yes, stay/travel duration with date

History of visit to wet/seafood market: Yes No From:..../...../..... to:...../...../.....

Close contact with confirmed case Yes NO Close contact with animal/birds Yes / N

Recent travel to any other country Yes NO Travel place: .....

Health care worker working in hospital involved in managing patients YES / NO, _____

Hospitalization date: ...../...../..... Discharge date: ...../...../.....

CLINICAL SYMPTOMS AND SIGNS

Date of onset of symptoms: ...../...../..... First symptom: .....

Symptoms	*Yes*	*No*	*Symptoms*	*Yes*	*No*	*Symptoms*	*Yes*	*No*	*Symptoms*	*Yes*	*No*
Fever at evaluation			**Cough**			Diarrhoea			Abdominal pain		
History of fever			**Breathlessness**			Nausea			Vomiting		
			Sore throat			Body-ache			Haemoptysis		
Chest pain			Sputum						Nasal discharge		

Signs	*Yes*	*No*	*Sign*	*Yes*	*No*	*Sign*	*Yes*	*No*
Wheeze			Stridor			Lower chest indrawing.		
Nasal flaring			Crepitation			Accesary muscle use		

UNDERLYING MEDICAL CONDITIONS

Condition	*Yes*	*No*	*Condition*	*Yes*	*No*	*Condition*	*Yes*	*No*	*Condition*	*Yes*	*No*
COPD			Bronchitis			Diabetes			Hypertension		
Chronic renal disease			Malignancy			Heart disease			Asthma		

IMMUNOCOMPROMISED CONDITION: YES / NO _____ Other: .....

HOSPITALIZATION, TREATMENT AND INVESTIGATION

HOSPITALIZATION date: ...../...../..... **DIAGNOSIS:** _____

DIFFERENTIAL DIAGNOSIS: _____ **ETIOLOGY IDENTIFIED:** _____

ATYPICAL PRESENTATION: YES / NO _____ **UNUSUAL / UNEXPECTED COURSE:** YES / NO

OUTCOME: Discharge / Death / _____ OUTCOME date:...../...../.....

Treatment	**Yes**	**No**	**Treatment**	**Yes**	**No**	**Treatment**	**Yes**	**No**	**Treatment**	**Yes**	**No**
Antibiotics			Ventilation			Antivirals			Steroids		
Oxygen			CPAP			Bronchodilators			Other:.....		

Investigation findings: Haematocrit: ..... Hb: ..... WBC (leukocyte count): .....
Differential Leukocyte count: Lymphocytes (%): ..... Monocytes (%): ..... Neutrophils (%):.....
Basophils (%): ..... Eosinophil (%): ..... Platelet (Thrombocyte) count: ..... ESR: .....

Investigation details: Chest X ray: Yes No , If yes (findings): .....
Blood culture findings (If any): ..... Other investigation details: .....

SPECIMEN INFORMATION FROM REFERRING AGENCY

Specimen type	Collection date	Label	FOR OFFICE USE ICMR-NIV	Specimen ID	Test performed	Result
1. BAL/ETA/__						
2.TS/NPS/NS						
3. Blood in EDTA						
4. Acute sera						
5 Convalescent sera						

Name of Doctor: ..... Hospital Name/address: .....
Phone/mobile number: ..... Signature and date: .....

PLEASE REFER THE CASE DEFINITION CHECKLIST ON PAGE 2. FOR SPECIMEN COLLECTION GUIDELINES, VISIT **www.niv.co.in**

For any sharing of information or for any query, contact Dr. Yogesh Gurav Scientist E (020-26006290/26006390).

ICMR- National Institute of Virology, Pune
Specimen Referral Form for 2019 Novel Coronavirus (2019-nCoV)

Name of the patient: ..... Age: .....years.....months

Note: Please ensure that the case definition should be strictly followed.
Please encircle the correct response (Yes/No)

CASE DEFINITION

1. Severe Acute Respiratory Illness (SARI), with

- history of fever YES / NO
- cough YES / NO
- requiring admission to hospital YES / NO

WITH

- no other etiology explains the clinical presentation YES / NO
  (clinicians should also be alert to the possibility of atypical presentations in patients who are immunocompromised);

AND

any of the following

- A history of travel to Wuhan, Hubei Province China in the 14 days prior to symptom onset. YES / NO
- the disease occurs in a health care worker who has been working in an environment where patients with severe acute respiratory infections are being cared for, without regard to place of residence or history of travel YES / NO
- the person develops an unusual or unexpected clinical course, especially sudden deterioration despite appropriate treatment, without regard to place of residence or history of travel, even if another etiology has been identified that fully explains the clinical presentation. YES /NO

2. Individuals with acute respiratory illness of any degree of severity who, within 14 days before onset of illness, had any of the following exposures:

- close physical contact with a confirmed case of nCoV infection, while that patient was symptomatic; YES / NO
- a healthcare facility in a country where hospital associated nCoV infections have been reported; YES / NO
- direct contact with animals (if animal source is identified) in countries where the nCoV is known to be circulating in animal populations or where human infections have occurred as a result of presumed zoonotic transmission*. YES / NO

* To be added once/if animal source is identified as a source of infection

EMAIL ID OF THE HEALTH AUTHORITY (FOR SENDING THE REPORT): .....

Name of Doctor: ..... Hospital Name/address: .....

Phone/mobile number: ..... Signature and date: .....