Reg. under PNDT Act 1994

Dr. Alpesh Patel, Ph.D.
Cytogeneticist

Dr. Shiva Shankaran Chettiar, Ph.D.
Molecular Geneticist

Gene plore
Diagnostics & Research Centre Pvt. Ltd.

CLINICAL & EPIDEMIOLOGICAL DATA FOR COVID 19

Name Of Doctors/Health Personal.....

District..... State.....

Tel.....

Name Of Hospital.....Ward.....

Patient's Name.....CR/OPD No .....

Age.....Sex.....Tel. No.....

Address.....

District.....State.....Occupation.....

Date of onset of illness..... Date of Admission.....

Vaccination Details :

Vaccine Type : _____ , 1St Dose : _____ 2nd Dose _____

Clinical Signs & symptoms:

Fever axilla>38^{0}C	Yes	☐	NO	☐
Oral > 38.5^{0}C	Yes	☐	NO	☐
Cough	Yes	☐	NO	☐
Sore throat	Yes	☐	NO	☐
Nasal catarrh	Yes	☐	NO	☐
Shortness of breath (difficulty in breathing)	Yes	☐	NO	☐

Exposure History:

Country Visit Date of visit. ☐ e. ☐

Close contact with a person (within 7 day) who is confirmed case of influenza A (H1N1.)

Yes ☐ No ☐

Travel to community (Within 7 day) where one or more confirmed case of influenza A (H1N1) have been reported. Yes ☐ ☐

Resides in a community where there are one or more confirmed influenza cases.

Yes ☐ No ☐

Sample Collection: Date:.....Type: throat swab/ nasopharyngeal swab/other.....

No. Of samples collected:.....

Treatment History: Treatment taken Yes ☐ No ☐ If yes what & when.....

Investigations Done: Yes ☐ No ☐

Chest X-Ray findings.....,**Email ID for reporting**.....

Registered Office : B/301-302, Tulip Corpus, Above Pakwan Dining Hall, Opp. V. S. Hospital, Ellisbridge, Ahmedabad-06, Gujarat India.
Ph. : 079-26584044/55, **M. :** 09586022587 **e-mail :** info@genexplore.co.in **web :** www.genexplore.co.in

Reg. under PNDT Act 1994

Dr. Alpesh Patel, Ph.D.
Cytogeneticist

Dr. Shiva Shankaran Chettiar, Ph.D.
Molecular Geneticist

Genexplore
Diagnostics & Research Centre Pvt. Ltd.

SECTION B – MEDICAL INFORMATION

B. 1 CLINICAL SYMPTOMS AND SIGNS

Symptoms: Yes Or No If No please go to B.2 section

Symptoms	yes	Symptoms	yes	Symptoms	yes	Symptoms	yes
Cough	__	Diarrhea	__	Vomiting	__	Fever at Evaluation	__
Breathlessness	__	Nausea	__	Haemoptysis	__	Body Ache	__
Sore Throat	__	Chest Pain	__	Nasal Discharge	__	Sputum	__
Abdominal Pain	__						

Which of the above mentioned was First Symptom: ..... Date of onset of First Symptom: _____

B.2 PRE – EXISTING MEDICAL CONDITIONS

Condition	Yes	Condition	Yes	Condition	Yes
Chronic Lung Disease	__	Malignancy	__	Heart Disease	__
Chronic Renal Disease	__	Diabetes	__	Hyper tension	__
Chronic Liver Disease	__				

Immunocompromised Condition: Yes / No Other underlying conditions:.....

B.3 HOSPITALIZATION DETAILS

Hospitalized: Yes / No Hospital State: .....

Hospital ID / Number: ..... Hospital District: .....

Hospitalization Date: __/__/__ (DD/MM/YY) Hospital Name: .....

B.4 REFFERING DOCTOR DETAILS

*Name Of Doctor: ..... Doctor Mobile No: .....

Doctor Email Id: .....

*Fields Marked with asterisk are mandatory to be filled

TEST REUSLT (To be filled by 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 Authoriy (Lab in Charge)