NATIONAL CENTRE FOR DISEASE CONTROL, DELHI
PATIENT PROFORMA FOR 2019-nCoV TESTING

State: **District:** **Name of Nodal Officer** **Mobile No*** **Email ID:**

Name:	Age/sex:	
Name of the Hospital:	Ward/OPD/ ICU:	Unit:
Patient ID No.:	Patient Resi. Address:	Mobile No:
Date of Hospital visit:	Date of hospital admission:	

Clinical symptoms (Pl mention beside each symptom if date of onset is different):

Date of symptoms onset:			
Fever: Y☐ /N☐	Chills: Y☐ / N☐	Duration: ☐ <7days / ☐ >7days	
Cough: Y☐ /N☐	Productive: Y☐ / N☐	Sore Throat: Y☐ / N☐	
Breathlessness: Y☐ / N☐	Myalgia: Y☐ / N☐	Headache: Y☐ / N☐	
Nausea: Y☐ / N☐	Vomiting: Y☐ / N☐	Abdominal pain: Y☐ / N☐	
Diarrhea: Y☐ /N☐	Any other symptom: (pl mention with date of onset)……....		

Clinical signs

Presence of any co-morbidities in the patient: Y☐ / N☐ (Pl mention the details below):

Lung Disease……/Hypertension……/Heart disease……/ Kidney Disease ……/
Liver Disease……/Blood Disorders……/Diabetes……/Metabolic Disorder……/
Cancer……/Immunocompromised……/Pregnancy (Pl mention trimester)…… /
Any other……

History of possible exposure to 2019-nCoV:

International Travel: Y☐ / N☐ Country *(China/other):……..Place(Wuhan/other):……..……..
Duration of stay:…… Date of departure: ……
Date of arrival to India:……..
*In case of travel to multiple countries, even transiently (pl mention details)……
H/o exposure to a confirmed/ suspected case of 2019-n CoV: Y☐ / N☐ Date:……
H/o exposure to any person with above symptoms who has further H/o of exposure to a confirmed case of 2019-nCoV:
Y☐/N☐ Date:……
Is the person, a health care worker Y/N……
If HCW, H/o of treating a unusual cluster of cases with above mentioned symptoms: Y☐ / N☐ Date:……..

Differential Diagnosis: ……

Treatment History (Pl mention the details of any chronic medication also) :

Indication	Name of the drug	Date of administration	Duration

Investigation details and findings:

Hematological: …….. Microbiological:……..

Radiological: …….. Any other: ……

Details of the sample:

Type of sample (Pl tick, including more than one type):
Nasopharyngeal swab/ Oropharyngeal swab / Nasopharyngeal aspirate / BAL/ Tracheal Aspirate / Sputum / Serum/
Any other (Pl mention): ……..
Date of sample collection:……. Date of sending sample:……. Date of sample receipt:……..

Remarks:

*: For conveying results of testing