SHOWRYA BIOHYDRO LABS

(Accreditation and Approved by NABL)

No-238, Katha, No-887, Old No- 31, Vidya Nagar Cross, Sonnapanahalli Panchayath, Jalahobli, Bengaluru Urban, Bangaluru, Karnataka, India
Ph: +91-88858 83399, +91- 81235 58555
E-Mail: showryalabs@gmail.com, showryalabsreport@gmail.com

SAMPLE REQUISITION FORM (PATIENT PROFORMA FOR SARS-CoV-2 TESTING)

MC-4565

Name of the Patient		Nationality	
Age		Gender	
Address		District	
Mobile number		State	
Doctor/ Hospital Name		Date of Collection	
Is the patientquarantined?	Yes/No		
Status of Clinical symptoms:	☐ Symptomatic	☐ Asymptomatic (Tick which is applicable)	

If Symptomatic Date of onset of symptoms:

Fever:	Yes/No ☐	Chills:	Yes/No ☐	Duration: ☐ <7Days	☐ >7Days
Cough:	Yes/No ☐	Dry Cough:	Yes/No ☐	Sore Throat:	Yes/No ☐
Difficulty in Breathing:	Yes/No ☐	Muscle Pain:	Yes/No ☐	Headache:	Yes/No ☐
Nausea:	Yes/No ☐	Vomiting:	Yes/No ☐	Abdominal Pain:	Yes/No ☐
Diarrhea:	Yes/No ☐	Any other symptom: (pl. mention with date onset):			

History of possible exposure to lab confirmed case of 2019-nCoV (SARS-CoV-2): Yes/No ☐

International Travel: Yes/No ☐ Country..... Place/City:.....

Duration of stay: .....

Date of arrival to India: .....

*In case of travel to multiple countries, even transiently (please mention details):

Is the person, a health care worker: Yes/No ☐

If HCW, H/o of treating an unusual cluster of cases with above mentioned symptoms: Yes/No ☐

Underlying Medical Conditions (Please Tick below mentioned condition applicable to patient):

COPD ☐	Bronchitis ☐	Diabetes ☐	Hypertension Chronic ☐
Renal Disease ☐	Malignancy ☐	Heart disease ☐	Asthma ☐
Immunocompromised Condition: Yes/No ☐			Other:

History of Hospitalizations (If Yes, Please mention the details of any chronic medication also) :

Indication	Name of the drug	Date of administration	Duration

Any other tests done (Please give details):

Type of sample (Pl tick, including more than one type):		
Nasopharyngeal swab/ Oropharyngeal swab (Yes/No) Any other (please mention)		
Valid Govt. ID attached Showing address proof (Specify: Aadhaar/VoterID/Driving License/Passport)		
Doctor Name:	Reg. No:	Doctor Signature:
Mobile:	Email:	Stamp:

***PLEASE ATTACHED THE XEROX COPY OF AADHAR CARD TO THIS SRF**