NAME(CAPITAL LETTERS)					
Age/Sex					
Cr. No					
Date of Admission					
Phone No					
No. belongs to					
Address					
Sample type					
Collection Date					
Time of Collection					
Area of Collection + Department					
ICMR Clinical Category of Pt.					
Travel History &Date of travel					
Contact with Confirmed Case					
Quarantine: If yes, write facility (Home/facility)					
Symptoms					
First symptoms & Date					
Underlying conditions					
Doctor on duty					
Consultant name					