(Not applicable for surgery and pregnancy cases)

Name of the Doctor_____
Registration No._____
Address _____
_____
Date:_____

To,
Name of the Laboratory,
_____

I have examined Mr. / Mrs. / Master / Miss _____ _____
aged about _____ years, physically, on_____date.

Details of the patient are as follows:

Residential Address	
Aadhar Card No.	
PAN Card No. (optional)	
Mobile phone No.	

The above referred patient is suffering from*

Cough	Diarrhoea	Vomiting	Fever at evaluation	Abdominal pain
Breathlessness	Nausea	Haemoptysis	Body ache	
Sore throat	Chest pain	Nasal discharge	Sputum	

and therefore, the patient is referred to carry out the RT-PCR test for corona virus.

I am aware of the ICMR guidelines regarding COVID-19 and the testing protocol.
I certify that above patient is symptomatic and is referred as per ICMR guidelines and MCGM testing protocol.

I am aware that if I fail to follow the ICMR guidelines / MCGM testing protocol, I am liable for action deemed fit by MCGM, including cancellation of MCI registration.

* *Please tick-mark the appropriate symptom.*

(Signature)
Name of the Doctor
(Please affix rubber stamp)