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COVID -19 (SARS-CoV-2) REQUEST FORM

Patient Surname		Other Names			
Date of Birth	DD MM YYYY Gender(✓) M F	Medical Aid		Authorization No:	
Accounts to Mr/ Mrs/ Miss/ Dr/ Prof)		Medical Aid No.		Lab No.	
Address/ Postal Address				ID No.	
Cell No.		Email			

I understand and agree to comply with the terms of legal declaration and consent to be tested for Covid-19 (SARS-COV-2).
I am satisfied with the information given regarding the sample collection procedure, testing and payment terms.
I agree to have my results shared with the Ministry of Health/Requesting doctor/requesting organization.

Signature of client/ Patient:

Referring Doctor		Dr's Email Address	

Relevant Clinical Data and Present Medication: LMP [D][D][M][M][Y][Y][Y][Y] FASTING (✓) [ ] YES [ ] NO **URGENT** [ ] **ROUTINE** [ ]

Patient physical address

County: Country:

Travel History

Country: Travel date: Travel time:

Passport No:

Clinical information

Date of onset of symptoms: [D][D]/[M][M]/[Y][Y] Y][Y]

Contact with a known positive case: No ( ) Yes ( ) Date of isolation:

Occupation: Patient's Temperature (°C)

Patient symptoms (tick all that apply)

- ☐ History of fever/ chills
- ☐ General weakness
- ☐ Cough
- ☐ Sore throat
- ☐ Runny nose
- ☐ Others (Specify)
- ☐ Shortness of breath
- ☐ Diarrhoea
- ☐ Nausea/vomiting
- ☐ Headache
- ☐ Irritability/Confusion
- ☐ Pain (tick all that apply)
  - ( ) Muscular ( ) Chest
  - ( ) Abdominal ( ) Joint

TESTS (Tick below)

- ☐ PCR SARS-CoV -2
- ☐ Antigen test SARS-CoV -2

SAMPLE TYPE

- ☐ Nasopharyngeal swab
- ☐ Oropharyngeal swab
- ☐ Sputum
- ☐ BAL
- ☐ Tracheal Aspirate

				FOR LABORATORY USE
Collected by	Date	Received by	Logged by	
	Time	Date / Time	Checked by	