PathCare Vermaak

PR NO. 0520000047368

FOR URGENT RESULTS

Contact Person

Please indicate Tel | Fax | Cell | Email

Contact number

BARCODED STICKER AREA

SARS-CoV-2 REQUEST FORM

BARCODE STICKER

* REFERRING DR.

1st Copy Dr & Code

2nd Copy Dr & Code

3rd Copy Dr & Code

Hospital Ward and Code

* REF DR CODE

File No.

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT (* compulsory - please complete)

REQ. INFO

* Patient ID Passport nr

DOB

* Patient Surname

* M F

* Patient First Name

* Patient Title

* Guarantor ID No.

* Title Mr Mrs Ms Dr Prof

* Surname

* Initials

* Postal Address

HOSPITAL STICKER

* Tel. (h) / cell

* Tel. (w)

* E-mail

* Patient Residential address

* Address

* City

* Postal Code

* Province

* Tel. (h) / cell

* Tel. (w)

* E-mail

* Medical Aid

* Medical Aid No.

* ICD 10 CODE

IMPORTANT

SPECIMEN INFORMATION AND TEST COUNT

URINE	HEPARIN	EDTA 4ml	EDTA 6ml	CITRATE	GEL	ACD	CLOTTED	FLUORIDE	OTHER - please specify	TEST COUNT

* Collected by

* Date DD MM YYYY

* Time

Priority

Location Code

* Received by

* Date DD MM YYYY

* Time

Births Single ☐ Twins ☐ 1 2 Triplets ☐ 1 2 3

OTHER TESTS AND CODES

RELEVANT CLINICAL DATA AND PRESENT MEDICATION

☐ **Healthcare Worker**

I certify that the above information is correct. I give specific consent for tests analysis and fully understand the implications of the test(s) and I have received adequate pre-test counselling. I hereby request and agree that all my pathology test results and accounts from DR WJH Vermaak Inc - (PathCare Vermaak) may be sent to my nominated email address and cellphone number, to my medical aid administrators, medical professionals and/or insurance company. I indemnify PathCare Vermaak against action that may be brought by virtue of this request and I understand that it is entirely my responsibility to safeguard access to my email and cellphone. I undertake to pay outstanding account balance not covered by the medical aid.

SIGNATURE PATIENT CONSENT

MSARSCOV2 ☐ SARS-CoV2 Diagnostic

OR

MCOVIDADMIS ☐ SARS-CoV2 Pre-admission and other screening

MINFPCR ☐ Influenza A&B / RSV PCR (GeneXpert)

SCOVAG1 ☐ SARS-Cov-2 Ag
Antigen test with confirmatory PCR if antigen is negative (RECOMMENDED, 2 swabs required)

SCOVAG2 ☐ SARS-Cov-2 Ag
Antigen test without confirmatory PCR (not recommended due to low sensitivity of antigen test)

For Pre-admissions please indicate Hosp Name: _____

Expected admission date: _____

Specimen Type (for office use only)

☐ Combines NP/OP swab
☐ Nasopharyngeal (NP) swab
☐ Oropharyngeal (OP) swab
☐ Nasal swab
☐ Sputum
☐ Tracheal aspirate
☐ Bronchoalveolar lavage
☐ Lung tissue from biopsy
☐ Other: _____

Specimen viability: Specimen viability is 5 days at 2-8°C

Clinical Presentation

Date of symptom onset: DD/MM/YYYY

None (asymptomatic) Y☐ N☐

Symptoms (reason for seeking care, tick all that apply):

Fever (≥38°C)	Y☐ N☐	Sore throat	Y☐ N☐	Myalgia/body pains	Y☐ N☐		
History of fever	Y☐ N☐	Shortness of breath	Y☐ N☐	General weakness	Y☐ N☐		
Cough	Y☐ N☐	Nausea/vomiting	Y☐ N☐	Irritability/confusion	Y☐ N☐	Other:	
Chills	Y☐ N☐	Diarrhoea	Y☐ N☐	Loss of smell or taste	Y☐ N☐	Specify_____	