



BARCODED STICKER AREA

FOR URGENT RESULTS

COVID-19 FORM
BARCODE STICKER

PRACTICE NO. 5200539

Contact Person

Please indicate Tel Fax Cell Email

Contact number

* REFERRING DR.

1st Copy Dr & Code

3rd Copy Dr & Code

2nd Copy Dr & Code

Hospital Ward and Code

* PATHCARE CODE

File No.

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

* Guarantor ID No. Title Mr Mrs Ms Dr Prof

REQ. INFO

* Patient ID Passport nr

DOB

* Surname

* Initials

* Patient Surname

* M F

* Postal Address

* Patient First Name

* Patient Title

* Tel. (h) / cell

* Tel. (w)

* E-mail

* Tel. (h) / cell

* Tel. (w)

* Patient Residential address

* E-mail

* Address

* Medical Aid

* City

* Medical Aid No.

* ICD 10 CODE

* Postal Code

SPECIMEN INFORMATION AND TEST COUNT

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

* Province

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 Drs. Dietrich, Voigt, Mia & Partners ("PathCare") may be sent to my nominated email address, to my medical aid administrators, medical practitioner(s) and/or insurance company. I indemnify PathCare 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. I undertake to pay outstanding monies not covered by the medical aid.

* Collected by

* Date DD MM YYYY

* Time

* Priority

Location Code

* Received by

* Date DD MM YYYY

* Time

Births Single Twins Triplets

OTHER TESTS AND CODES

RELEVANT CLINICAL DATA AND PRESENT MEDICATION

LMP DD MM YYYY

FASTING YES NO

SIGNATURE PATIENT CONSENT

Please tick only one of the following COVID-19 options:

COVID -19 diagnostic

P4516 Inpatient symptomatic

D5897 Outpatient symptomatic

P4516 Health care worker

COVID-19 pre-admission

D5897 Hospital admission (non-COVID-19 related)

Y4514 Pre-surgery or other screening

M4789 COVID-19 antibody testing (tick only one)

Retrospective diagnosis of COVID-19 (Including MIS-C)

Epidemiological purposes

Scientific research studies and clinical trials

Specimen requirements:

1. Lower respiratory tract specimen (e.g. sputum, tracheal aspirate, bronchoalveolar lavage); or
2. Single nasopharyngeal swab placed into the supplied tube; if not available an oropharyngeal swab placed into the supplied tube; or
3. Lung tissue from biopsy.
4. SARS-CoV-2 antibody testing: EDTA or SST

Transportation: cold, on ice if transport is expected to exceed 6 hours

Specimen viability: 2 days, if refrigerated.

Clinical Presentation

Date of symptom onset: DD/MM/YYYY

None (asymptomatic) Y N

Fever (≥38°C) Y N Sore throat

Y N Myalgia/body pains Y N

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

Chills Y N Diarrhoea

Y N Other Y N Specify _____

COVID-19 CONTACT LINE LIST

Complete a contact line list for every person under investigation for Coronavirus disease 2019 (COVID-19).

Details of person under investigation/confirmed COVID-19 case

RSA Identity number / Passport number _____ Residential address _____

First name _____

Surname _____ District _____

Contact number _____ Province _____

Date of birth _____ Date of sample collection _____ Testing laboratory _____

Details of contacts (With close contact from the date of symptom onset, or during symptomatic illness.) (for screening purposes during last 72h)

| | Surname | First name(s) | Sex (M/F) | Age (Y) | Relation to case ² | Date of last contact with case | Place of last contact with case (Provide name and address) | Residential address (for next month) | Phone number(s), separate by semicolon | HCW ³ or school-going/teacher? (Y/N) If Yes, facility/school name |
|---|---------|---------------|-----------|---------|-------------------------------|--------------------------------|--|--------------------------------------|--|---|
| 1 | | | | | | DD/MM/YYYY | | | | |
| 2 | | | | | | DD/MM/YYYY | | | | |
| 3 | | | | | | DD/MM/YYYY | | | | |
| 4 | | | | | | DD/MM/YYYY | | | | |
| 5 | | | | | | DD/MM/YYYY | | | | |
| 6 | | | | | | DD/MM/YYYY | | | | |
| 7 | | | | | | DD/MM/YYYY | | | | |
| 8 | | | | | | DD/MM/YYYY | | | | |

¹ Close contact: A person having had face-to-face contact (≤ 2 metres) or was in a closed environment with a COVID-19 case; this includes, amongst others, all persons living in the same household as a COVID-19 case and, people working closely in the same environment as a case. A healthcare worker or other person providing direct care for a COVID-19 case, while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection). A contact in an aircraft sitting within two seats (in any direction) of the COVID-19 case, travel companions or persons providing care, and crew members serving in the section of the aircraft where the index case was seated. ² Chose from: Spouse, Aunt, Child, Class mate, Colleague, Cousin, Father, Friend, Grandfather, Grandmother, Healthcare worker taking care of, Mother, Nephew, Niece, Other relative, Uncle. ³ Healthcare worker.

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|---------|---------------|-----------|---------|-------------------------------|--------------------------------|--|--------------------------------------|--|---|
| 9 | | | | | DD/MM/YYYY | | | | |
| 10 | | | | | DD/MM/YYYY | | | | |
| 11 | | | | | DD/MM/YYYY | | | | |
| 12 | | | | | DD/MM/YYYY | | | | |
| 13 | | | | | DD/MM/YYYY | | | | |
| 14 | | | | | DD/MM/YYYY | | | | |
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| 18 | | | | | DD/MM/YYYY | | | | |
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| 20 | | | | | DD/MM/YYYY | | | | |
| 21 | | | | | DD/MM/YYYY | | | | |

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