PRACTICE NO. 5200539

BARCODED STICKER AREA

TRAVEL COVID-19 FORM

BARCODE STICKER

FOR URGENT RESULTS

Please indicate	Tel	Fax	Cell	Email

* REFERRING DR.	TRAVEL AUTHORITY	1ST Copy Dr & Code	PATIENT	3rd Copy Dr & Code	
* PATHCARE CODE	COVID19	2nd Copy Dr & Code		File No.	

REQUIRED INFO

* Traveller ID		DOB	DD MM YYYY
* Traveller Surname		* Gender	M F
* Traveller Names (as on Passport)		* Traveller Title	
* Passport No.		* Date & Time of Flight	DD MM YYYY HH : MM
* Tel. Local cell			
* E-mail		* Tel. (alt)	
* Traveller Local address			
* Address			
* City		* Postal Code	
* Province			

* Collected by		* Date DD MM YYYY	* Time
Site Priority	S ☐ U ☐ H ☐ R ☐ Z ☐		
* Identity Verified	STAFF SIGNATURE		
* Received by		* Date DD MM YYYY	* Time

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 and cellphone number, 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.

SIGNATURE TRAVELLER'S CONSENT

V5928 ☐ **Travel/Tourist COVID-19 PCR**

MEDICAL AID : SD CORONA

MEDICAL AID NO : RECEIPT NO ……………………………………

AMOUNT ……………………………………

M5939 ☐ **Travel to China**

MEDICAL AID : SD CHINA

MEDICAL AID NO : RECEIPT NO ……………………………………

AMOUNT ……………………………………

Specimen requirement:

V5928: Single nasopharyngeal swab placed into the supplied tube; If not available, an oropharyngeal swab placed into the supplied tube.

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

M5939: Single nasopharyngeal swab placed into the supplied tube; If not available, an oropharyngeal swab placed into the supplied tube.
SST (transport on ice).

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

By requesting the above test, I confirm and acknowledge the following:

1. I do not currently suffer from any COVID-19 symptoms and signs, including fever, flu-like symptoms, loss of smell and taste, muscle pains, shortness of breath, etc.
2. I am not currently in self-isolation due to exposure to a COVID-19 infected individual.
3. I realise that this screening test is only for travel purposes. It is not for diagnostic or clinical purposes.
4. I understand that PathCare is mainly a referral laboratory and it is my responsibility to seek further care from my general or family practitioner in the event of my test being positive.
5. If the test is positive, it will be my duty and responsibility to self-isolate with immediate effect and to obtain medical assistance if indicated.
6. I realise that COVID-19 is a notifiable disease and that the Department of Health will be informed accordingly.
7. I understand that PathCare may share my result with the embassy/consulate of the country I intend to enter, should they receive such a request.
8. Travellers must check the spelling of their names on results as an incorrect name could lead to the airline barring you from departure. Any corrections must be timeously notified to 021 596 2130
9. Travellers testing positive for COVID-19 are presumably asymptomatic. False positive COVID-19 PCR tests are unusual but false negative tests are frequently seen, especially in asymptomatic patients. Subsequent tests may prove negative depending on a range of factors including but not limited to the shedding rate of the virus, immune response and sample quality. Drs Dietrich, Voigt, Mia & Partners takes no responsibility for ANY claims of whatsoever nature or any consequential losses relating to test results falling within the aforementioned category.
10. PathCare will make every effort to ensure the timely analysis of the sample, however, we cannot take responsibility for reimbursing missed flights or other costs as a result of tests results not being available or being available earlier than indicated.

SIGNATURE TRAVELLER'S CONSENT

Contact Line List:

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 case²	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	HCW³ 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				

* *If you were in contact with more than 5 people, please complete a separate contact line list (available on our website)*