PathCare

Covid

BARCODED STICKER AREA

COVID-19 REQUEST FORM

BARCODE STICKER

FOR URGENT RESULTS

Contact Person

Please indicate Tel | Fax | Cell | Email

Contact number

* **REFERRING DR.**

1st Copy Dr & Code

2nd Copy Dr & Code

3rd Copy Dr & Code

Hospital Ward and Code

* **PATHCARE 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

* Tel. (h) / cell

* Tel. (w)

* Patient Residential address

* E-mail

* Address

* Medical Aid

* City

* Medical Aid No.

* ICD 10 CODE

IMPORTANT

* Postal Code

* Province

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

LMP D D M M Y Y Y Y

FASTING YES NO

I certify that the above information is correct. I give specific consent for test analysis and fully understand the implications of the test(s) and I have received adequate pre-test counselling. I consent to the processing of my personal information for the purposes of this test request. 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 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 hereby agree to PathCare's privacy policy and terms and conditions available at www.pathcare.co.za. I undertake to pay outstanding monies not covered by the medical aid.

SIGNATURE PATIENT CONSENT

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

COVID -19 diagnostic PCR

- P4516 ☐ Inpatient symptomatic
- D5897 ☐ Outpatient symptomatic
- P4516 ☐ Health care worker

COVID-19 pre-admission PCR

- D5897 ☐ Hospital admission (non-COVID-19 related)
- Y4514 ☐ Pre-surgery or other screening

COVID-19 Antigen Test (ER unit, symptomatic patients only)

- F4124 ☐ Antigen test with confirmatory PCR if antigen negative (RECOMMENDED, 2 swabs required)
- D5943 ☐ Antigen test without confirmatory PCR (not recommended due to low sensitivity of antigen test)

COVID-19 rapid PCR

- H2548 ☐ Only available for critical diagnostic purposes; prior arrangement with pathologist required.

COVID-19 Antibody testing

- M4789 ☐ SARS-CoV-2 IgG (N-antibody)
- S5972 ☐ SARS-CoV-2 IgG (S-antibody – post vaccine)

Let our Carebot assist you to:

- Pre-register a profile
- Manage your account
- Receive a copy of your COVID-19 results

Scan the QR Code or add **021 596 2130** to your contacts and send us a 'Hi' in WhatsApp and follow the prompts

Specimen requirements:

COVID-19 Diagnostic testing PCR

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.

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

COVID-19 N-Antibody testing

EDTA or SST

COVID-19 S-Antibody testing

SST

Clinical Presentation:

Symptomatic? Yes ☐ No ☐

If symptomatic, please list symptoms: _____

Has the patient received a COVID vaccine Yes ☐ No ☐

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 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				

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