PathCare Namibia

LOCAL PATHOLOGISTS
DRS SHAW, ROUX & PARTNERS

GRF
PRACTICE NO.
052 000 000 6238

BARCODED STICKER AREA

CORONA VIRUS REQUEST FORM

BARCODE STICKER

FOR URGENT RESULTS

Contact Person

Please indicate | Tel | Fax | Cell | Email

Contact number

* REFERRING DR

* PATHCARE CODE

File No.

1st Copy Dr & Code

2nd Copy Dr & Code

3rd Copy Dr & Code

Hospital Ward and Code

HOSPITAL STICKER

* Patient ID Passport nr

DOB

* Patient Surname

* M F

* Patient First Name

* Patient Title

* Tel. (h) / cell

* Tel. (w)

* E-mail

* Patient Residential address

* Suburb

* City

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

* Guarantor ID No.

* Title Mr Mrs Ms Dr Prof

* Surname

* Initials

* E-mail

* Tel. (h) / cell

* Tel. (w)

* Medical Aid

* Medical Aid No.

* Postal Address

* Collected by

* Date

* Time

Priority

Location Code

* Received by

* Date

* Time

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

ICD10: Z11.5

Pathologist approval for random access test.

Name of approving pathologist

DR:_____

SPECIMEN INFORMATION AND COUNT

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

I certify that the above information is correct. I give specific consent for test analysis and fully understand the implications of the test(s). I have received adequate pre test counselling. I hereby request and agree that all my pathology accounts from Drs. Shaw, Roux & Partners ("PathCare Namibia") may be sent to my nominated email address, 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 undertake to pay outstanding monies not covered by medical aid.

SIGNATURE: PATIENT / GUARDIAN

SIGNATURE: PERSON RESPONSIBLE FOR PAYMENT IF DIFFERENT FOR PATIENT

D5897 ☐ **COVID-19 Diagnostic** **B5922** ☐ **Random Access COVID-19** (Pathologist approval required)

SPECIMEN TYPE

☐ Nasopharyngeal (NP) swab ☐ Oropharyngeal (OP) swab

☐ NP & OP swab ☐ Other (specify) **may result in a longer TAT** _____

REASON FOR TESTING

Urgent

☐ Hospital patient **(symptomatic)**

☐ Healthcare worker

☐ Truck driver **(cross border)**

Priority

☐ Quarantine **(2nd sample) Date of release** ☐☐☐☐☐☐☐☐

☐ Travel **(medical reasons) Date of travel** ☐☐☐☐☐☐☐☐ **(Please ensure your passport number is completed above)**

☐ Hospital admission **(pre op) Date of admission** ☐☐☐☐☐☐☐☐

Routine

☐ Contact tracing

☐ Travel **(non-medical) Date of travel** ☐☐☐☐☐☐☐☐ **(Please ensure your passport number is completed above)**

☐ Retest **(date of previous test)** ☐☐☐☐☐☐☐☐

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

V 1.00 NAMIBIA / Corona Virus testing request form Namibia 18 08 2020 (1M)