COVID-19 REQUEST FORM

DOCTOR'S INFORMATION

Referring Doctor: _____

Doctor's Prctice No.: _____

Hospital/Ward: _____

Copies to Doctor: _____   File No: _____

PART A: PATIENT DETAILS

First names (s): _____

Surname: _____   Gender: M / F

Passport No.: _____   Age: _____

Date of Birth: DD / MM / YYYY

Email: _____

Address _____

PART B: GUARANTOR'S

Account to: _____

Collected by:: _____

Date: DD / MM / YYYY   Time: _____

Cash: ____   Receipt No.: _____

Staff Signature: _____

PART C: PATIENT'S URGENT CONTACT

Contact person: _____

Tel: _____   Fax: _____

Cell: _____

Email: _____

Physical Address: _____

PART D: TRAVEL INFORMATION

Country of Origin: _____

Destination: _____

Date of Departure: DD / MM / YYYY

Date of Return: DD / MM / YYYY

Time of Departure: _____

Countries En route: _____

PART E: SARS -CoV-2 (COVID-19) Request

Test:

C19

○ PCR SARS-CoV-2   ○ PCR SARS-CoV-2 IgG/IgM

○ SARS-COV-2 Express   ○ SARS-COV-2 Super Express

○ SARS-COV-2 Antigen (No Certificate)

Types of Specimen:

○ Oropharyngeal Swab

○ Nasopharyngeal Swab

Reason for Testing:

○ General Screening

○ Outbound Passenger

PART F: CLINICAL PRESENTATION

Date of onset of Symptoms:

DD / MM / YYYY

Symptoms (Tick applicable):

○ Fever (38C)   ○ Short of breath

○ Cough   ○ Nausea / Vomiting

○ Chills   ○ Diarrhoea

○ Sore Throat   ○ Other

Specify other: ....
....

DECLARATION

I hereby declare that am aware that Covid-19 is a notifiable disease and as such MOHSS will be informed of any results thereto. Covid Test Nambia will not take any responsibility for claims that may arise due to delayed results and/or false positive/false negative results. I understand that these can arise due to several factors including, but not limited to the viral load and quality of the sample.

Signature: ....   Date: ....