



LOCAL PATHOLOGISTS
DRS SHAW, ROUX & PARTNERS



GRF
PRACTICE NO.
052 000 000 6238

BARCODED STICKER AREA

CORONA VIRUS
NO DR CONTACT TRACING
BARCODE STICKER

FOR URGENT RESULTS

Contact Person

Please indicate Tel Fax Cell Email

Contact number

* REFERRING DR. **NO DOCTOR CONTACT TRACING**

1st Copy Dr & Code

3rd Copy Dr & Code

* PATHCARE CODE **NODRCT**

File No.

2nd Copy Dr & Code

Hospital Ward and Code

* Patient ID Passport nr	DOB
* Patient Surname	* M F
* Patient First Name	* Patient Title
* Tel. (h) / cell	* Tel. (w)
* E-mail	

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	

* Patient Residential address
* Suburb
* City

* Collected by	* Date DD MM YYYY	* Time	
Priority	Location Code		
* Received by	* Date DD MM YYYY	* Time	
Births	Single <input type="checkbox"/>	Twins <input type="checkbox"/> (1 2)	Triplets <input type="checkbox"/> (1 2 3)

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 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 undertake to pay outstanding monies not covered by medical aid.

SIGNATURE : PATIENT / GUARDIAN

SIGNATURE : PERSON RESPONSIBLE FOR PAYMENT
IF DIFFERENT FOR PATIENT

ICD10: Z11.5

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

D5897 COVID-19 PCR STANDARD (N\$750.00)

F4124 Antigen test with confirmatory PCR if antigen negative (RECOMMENDED, 2 swabs: 1x NP and 1x OP required)

B5922 COVID-19 PCR XPRESS (N\$1200.00)

D5943 Antigen test without confirmatory PCR (N\$223.80)
(Not recommended due to low sensitivity, 1x NP swab required)

SPECIMEN TYPE

<input type="checkbox"/> Nasopharyngeal (NP) swab	<input type="checkbox"/> Oropharyngeal (OP) swab
<input type="checkbox"/> NP & OP swab	<input type="checkbox"/> 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

D	D	M	M	Y	Y	Y	Y
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Travel (medical reasons) Date of travel

D	D	M	M	Y	Y	Y	Y
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 (Please ensure your passport number is completed above)

Hospital admission (pre op) Date of admission

D	D	M	M	Y	Y	Y	Y
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Routine

Contact tracing

Travel (non-medical) Date of travel

D	D	M	M	Y	Y	Y	Y
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 (Please ensure your passport number is completed above)

Retest (date of previous test)

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