PathCare Namibia

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.
* 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

HOSPITAL STICKER

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.

* Patient Residential address
* Postal Address
* Suburb
* City

* 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

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

D5897 ☐ COVID-19 PCR STANDARD (N$700.00)
B5922 ☐ COVID-19 PCR XPRESS (N$1000.00)
Z5948 ☐ RAPID ANTIGEN TEST (N$250.00)

COVID-19 Antigen Test (ER unit, symptomatic patients only)
F4124 ☐ Antigen test with confirmatory PCR if antigen negative (RECOMMENDED, 2 swabs: 1x NP and 1x OP required)
D5943 ☐ Antigen test without confirmatory PCR (N$223.80) (Not recommended due to low sensitivity, 1x NP swab 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 D D M M Y Y Y Y
☐ Travel (medical reasons) Date of travel D D M M Y Y Y Y (Please ensure your passport number is completed above)
☐ Hospital admission (pre op) Date of admission D D M M Y Y Y Y

Routine

☐ Contact tracing
☐ Travel (non-medical) Date of travel D D M M Y Y Y Y (Please ensure your passport number is completed above)
☐ Retest (date of previous test) D D M M Y Y Y Y

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

Y / 00 NAMIBIA / COVID-19 Testing Form_Namibia 20.12.2021_KR