



LOCAL PATHOLOGISTS
DRS SHAW, ROUX & PARTNERS



GRF
PRACTICE NO.
052 000 000 6238

CORONA VIRUS
NO DR CONTACT TRACING
BARCODE STICKER

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
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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

D5897 COVID-19 PCR STANDARD

B5922 COVID-19 PCR XPRESS

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

D5943 Antigen test without confirmatory PCR (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