COVID-19 FORM – LUMEGEN LABORATORIES

Referring Doctor	

Patient Details				**Person Responsible for Payment of Account**			
Patient ID No.				ID No.			
Passport No.				Surname & Initial			
Surname				First name			
Initials		Title		Postal Address			
First Name							
Date of Birth	D D / M M / Y Y Y Y					Code	
Gender	M	F	Age	Telephone No.			
Patient Cell No				Cell phone No.			
Patient Email				Email			
Patient Physical Address	Town			**Patient/Guardian**: My signature indicates my understanding of and agreement to: Comply with the terms and legal declaration, provide consent for the processing of personal information and the release of test results. I give consent for tests and guarantee payment of any outstanding amounts.		Signature	
	Province						
	South Africa						

SARS-CoV-2 (COVID-19) PCR Test

Sample Type				Clinical Presentation / Onset of symptoms					
Nasopharyngeal Swab		Throat Swab		D D / M M / Y Y Y Y					
Nasal Swab		Sputum		Fever		Chills		Shortness of Breath	
Collected By				Cough		Sore throat		Nausea / Vomiting	

Reason for testing					
Contact with positive case		Healthcare Worker		Pre-Admissions or Pre-Surgery	
Traveller		Other (Specify)			
Collection Date	D D / M M / Y Y Y Y		Time Collected	H H / M M	