AFFIX
BARCODE LABEL HERE

COVID-19 REQUEST FORM

DIAGNOFIRM
MEDICAL LABORATORIES
PATHOLOGY YOU CAN TRUST!

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PRACTICE NO.: 52002

REFERENCE DATE	YR	MNTH	DAY	TIME

Client Information		**Submitter Information (Contact Person for results)**	
Identity No./Hospital No.		Surname	
Surname		First Name	
First Name		Facility / Hospital/Site	
Age / Date of Birth		City / Village	
Gender		Contact Number	
Nationality		Email Address	
Residence status	Resident ☐ Non-Resident ☐	Results Key Contact	
Contact Number		Clients Occupation	
Client's email address		Client's Employer	
Consent to Email Results Notification	Yes ☐ No ☐	Client's Employer Contacts	

Specimen Details

Specimen Collection Date: DD / MM / YYYY **Time of Collection:** HH / MM

Specimen Type: ☐ Combined NP/OP Swab ☐ Nasopharyngeal (NP) Aspirate ☐ Nasal Swab
☐ Nasopharyngeal (NP) Swab ☐ Bronchoalveolar Lavage (BAL) ☐ Sputum
☐ Oropharyngeal (OP) Swab ☐ Other, Specify:

Laboratory Test Details

Tests Required: ☐ SARS-COV-2 ☐ Influenza / RSV ☐ MERS-CoV ☐ Neonatal Sepsis ☐ Avian Influenza ☐ Other, Specify

Clinical Presentation and Outcome

Date of Symptom onset: DD / MM / YYYY

Clinical Diagnosis: ☐ Acute Rheumatic Fever ☐ Meningococcal Disease ☐ Lower Respiratory Tract Infection
☐ Diphtheria ☐ Influenza-like Illness ☐ Upper Respiratory Tract Infection
☐ Pertussis ☐ Meningitis ☐ Other, Specify:

Symptoms: ☐ Fever (≥38℃) ☐ Sore Throat ☐ Cough ☐ Headache ☐ Stiff Neck
☐ Shortness of Breath ☐ Vomiting ☐ Diarrhoea ☐ Paroxysmal Cough / Inspiratory Whoop
☐ Apnoea ☐ Other, Specify: _____ ☐ Unknown ☐ None

Underlying Risk Factors: ☐ Asthma ☐ Chronic Lung Disease ☐ Diabetes ☐ HIV ☐ Stiff Neck ☐ TB
☐ Heart Disease ☐ Other, Specify: _____ ☐ Unknown ☐ None

Case Classification:	**Hospitalization:**	**Outcome:**
☐ Contact of a Case	☐ Inpatient - not admitted ICU	☐ Still Hospitalized
☐ Quarantined / Isolation	☐ Inpatient - admitted to ICU	☐ Survived
☐ National Surveillance Program	☐ Outpatient ☐ Unknown	☐ Died ☐ Unknown
☐ Port of Entry (screening)		
☐ Other (specify)_____		

Exposure History

Did the patient travel in the 14 days prior to symptom onset? ☐ Yes ☐ No ☐ Unknown

Area/ Country travelled to:	Date of travel to this area	Date of travel from this area
1.		
2.		

Did the client have exposure contact in the 14 days prior to symptom onset? ☐ Yes ☐ No ☐ Unknown

Type of Exposure	Date of exposure	Other indications
☐ Swine/Poultry ☐ Wildbirds	DD / MM / YYYY	

LABORATORY REPORT *(For Laboratory Use Only; Relevant stamps can be used)*

Result: ☐ POSITIVE ☐ NEGATIVE ☐ INCONCLUSIVE

Results Reported by: _____ Date: DD / MM / YYYY

Results Verified by: _____ Date: DD / MM / YYYY