Dr AGP Jali (P.R. NO. 0885908)
Unit 11 Calypso Centre
10 Lira Link, Richards Bay
Email: info@izarpath.com
Tel: +27 (79) 879 7883
Whatsapp: +27 (79) 090 2706
Website: www.zarpath.com

QUALITY AT AFFORDABLE RATES

LABORATORY BARCODE

REFERRING DOCTOR		COPY DOCTORS	

I.D. NO.		GUARANTOR I.D. NO.	
SURNAME		SURNAME	
FIRST NAME	TITLE	FIRST NAME	TITLE
DATE OF BIRTH	GENDER M F AGE	POSTAL ADDRESS	
HOSP NO./FILE NO.	HOSPITAL PATIENT Y N	PHYSICAL ADDRESS	
PATIENT (H)	(W)	PATIENT (H)	(W)
PATIENT (CELL)		PATIENT (CELL)	EMPLOYER
PATIENT EMAIL		PATIENT EMAIL	
SPECIAL REQUEST	ROUTINE URGENT FASTING RANDOM	MEDICAL AID NAME	
COLLECTION DATE	TIME	MEMBER NUMBER	OPTION
PHLEBOTOMIST	Ethnic grp	AUTHORISATION NO.	DEP. CODE
RECEIVED DATE	TIME BY	CASH/CREDIT CARD	REC. NO

IS THIS A NEW CLINICAL QUERY: ☐

IS THIS A KNOWN CASE : ☐

KNOWN CASE:

FIRST NAME : ____________________

SURNAME : ____________________

D.O.B: ______________

GUARANTOR'S CONSENT

I certify that the above information is correct for the selected tests to be done. I undertake to pay all outstanding monies not covered by the scheme. Members Signature :

SARS-CoV-2 (COVID-19) REQUEST FORM

CLINICAL INFORMATION	ICD 10 CODES

Test : SARS CoV-2 PCR ☐

☐ Nasopharyngeal Swab ☐ Throat Swab

☐ Nasal Swab ☐ Other :___________

Next of Kin Full Name	
Relationship	
Contact Number	

Patients Current Address: ____

____

Occupation: ____________________________

Employer: ____________________________

Recent Travel: ____________________________

Departure: _______________ Return : ____________________

CLINICAL PRESENTATION

Date of symptom onset: DD/MM/YYYY ____________ None (asymptomatic) Y☐ N☐ Lab ref nr of sample ____________

Symptoms (reason for seeking care, tick all that apply):

Fever (≥38°C)	Y☐ N☐	Sore throat	Y☐ N☐	Myalgia/body pains	Y☐ N☐
History of fever	Y☐ N☐	Shortness of breath	Y☐ N☐	General weakness	Y☐ N☐
Cough	Y☐ N☐	Nausea/vomiting	Y☐ N☐	Irritability/confusion	Y☐ N☐
Chills	Y☐ N☐	Diarrhoea	Y☐ N☐	Other	Y☐ N☐ Specify______________

Details of contacts (*With close contact[1] from two days prior to date of symptom onset, or during symptomatic illness.*)

	Surname	First name(s)	Sex (M/F)	Age (Y)	Relation to case[2]	Date of last contact with case	Place of last contact with case (Provide name and address)	Residential address (for next month)	Phone number(s), separate by semicolon	HCW[3] or school-going/teacher? (Y/N) *If Yes, facility/school name*
1						DD/MM/YYYY				
2						DD/MM/YYYY				
3						DD/MM/YYYY				
4						DD/MM/YYYY				
5						DD/MM/YYYY				