AMPATH LABORATORIES

| | |
|---|---|
| REFERRING DOCTOR | DR JESSICA TRUSLER truje00 |
| COPY DOCTOR | chine01 Chinese Embassy Pretoria |

PLACE BARCODE HERE

sanas
Refer to www.sanas.co.za for a full list of accredited laboratories and tests.

PRIORITY STAT

| | | | |
|---|---|---|---|
| MEDICAL AID | travel | MEDICAL AID NO. | UPFRONT PAYMENT ONLY |

| PATIENT DETAILS | | PERSON RESPONSIBLE FOR ACCOUNT PAYMENT (GUARANTOR) | |
|---|---|---|---|
| ID / PASSPORT NUMBER | | GUARANTOR ID NUMBER | |
| SURNAME | TITLE | SURNAME | |
| INITIALS & FIRST NAME | AGE | INITIALS & FIRST NAME | TITLE |
| DATE OF BIRTH D D M M Y Y Y Y | GENDER M F | POSTAL ADDRESS | |
| PATIENT EMAIL | | | POSTAL CODE |
| PATIENT ☎ (H) | (W) | GUARANTOR ☎ (H) | (W) |
| PATIENT ☎ (CELL) | | GUARANTOR ☎ (CELL) | |
| SA PASSPORT/ FOLIO NO. | | EMAIL | |
| PATIENT/GUARDIAN SIGNATURES: I give consent to requested tests and guarantee payment thereof. I verify that all personal information is correct. | I consent that ICD10 codes may be provided to my medical aid as per statutory requirements on my a ccount. Y N | EMPLOYER | |
| COLL. DATE D D M M Y Y Y Y | COLL. TIME | | COLL. BY |

## COVID-19 TRAVEL PROFILE FOR CHINA ONLY

Patient Email Address: _____
Patient Residential Address: _____
_____ Postal Code: _____
Patient alternate contact number: _____
Required for travel Y N
If yes, final destination: _____
Date of departure: _____ Time of Departure: _____
Tested before Y N
Symptomatic Y N
Health care worker Y N
Priority/High risk Y N

**PAYMENT MADE BY**
☐ EFT **POP SUPPLIED** Y N
☐ CREDIT/DEBIT CARD
☐ CASH **RECEIPT NUMBER:**

**TEST**
COVID19PCR ☐ COVID-19 PCR
COVID19M ☐ COVID-19 IgM Antibodies

**SOURCE**
NPSW ☐ Nasopharyngeal swab Container: A04 x 1
BLOOD ☐ Container: S01 x 1

**TRAVELLER ACKNOWLEDGEMENT AND CONSENT**

By Patient (12 years and older) :
Name, Surname and Passport/ I.D. number:

Signed: _____

Address/e-mail:

Date: _____

By Patient's representative
Name, Surname and Passport/ I.D. number/address/e-mail:

Signed: _____
Being duly authorised to act for the patient in my capacity as:
Parent/Guardian/Curator/Administrator/Trustee/Child/ By Court Order/ Other:

Acting for the following Patient: Full names, surname, identity or passport numbers:

Date: _____

1. grants informed consent to having a COVID-19 PCR test conducted on patient for travel purposes the Patient and me being aware of:
   1.1 the range of diagnostic procedures and treatment options generally available;
   1.2 the benefits, risks, costs and consequences generally associated with each option;
   1.3 the Patient's right to refuse health services and the implications, risks, obligations of such refusal.
2. and understands that the report contains medical information which must preferably be interpreted by a registered medical doctor
3. understands and consents that if the COVID-19 PCR test is positive, the patient must immediately self-isolate and seek medical assistance should the patient require it;
4. and understands that it is my and or the patient's responsibility to ensure that patient's COVID-19 PCR report is timeously received i.e. within 72 hours prior to departure. Except where I and or the patient prove/s gross negligence on the part of the Laboratory, I and or the patient shall not keep the Laboratory liable in contract and or in delict if the test could not be conducted or the test result was late, delayed, marginally positive or negative, false positive or false negative. I/the patient understand that testing negative for COVID does not mean the Patient cannot be infected later or be infected within the said 72 hours;
5. that I, the patient have not been exposed to a COVID-19 positive person in the last 14 days, nor am I and or the patient displaying any COVID-19 or flu-like symptoms
6. and understand that for travel purposes, my/the patient's medical aid will not pay for this test and that I/the patient must pay upfront, prior to sample collection.
7. that I/the understand that these terms will apply whether I travel by air, land or by ship or any combination thereof.
8. and understands that my/the Patient Personal Information and specimen will be processed in accordance with relevant legislation.

| NO OF TUBES DRAWN | S01 | S02 | E01 | E02 | HEP | CIT | FLU | MICRO SPECIMEN | MOLECULAR SPECIMEN | OUR STANDARD PRICE LIST IS AVAILABLE AT THE DEPOT |
|---|---|---|---|---|---|---|---|---|---|---|