



PRIORITY STAT

MEDICAL AID travel	MEDICAL AID NO.	UPFRONT PAYMENT ONLY
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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	GENDER <input type="checkbox"/> M <input type="checkbox"/> 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 consent that ICD10 codes may be provided to my medical aid as per statutory requirements on my account. <input type="checkbox"/> Y <input type="checkbox"/> N	EMPLOYER	
COLL. DATE	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: _____

- grants informed consent to having a COVID-19 PCR test conducted on patient for travel purposes the Patient and me being aware of:
 - the range of diagnostic procedures and treatment options generally available;
 - the benefits, risks, costs and consequences generally associated with each option;
 - the Patient's right to refuse health services and the implications, risks, obligations of such refusal.
- and understands that the report contains medical information which must preferably be interpreted by a registered medical doctor
- 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;
- 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;
- 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
- 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.
- that I/the understand that these terms will apply whether I travel by air, land or by ship or any combination thereof.
- and understands that my/the Patient Personal Information and specimen will be processed in accordance with relevant legislation.