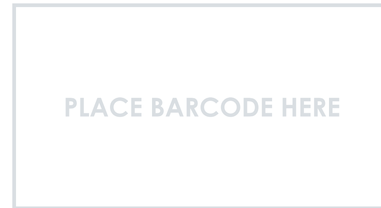
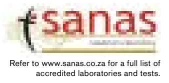
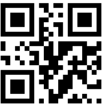
REFERRING DOCTOR	DR JESSICA TRUSLER	truje00
COPY DOCTOR	chine03 Chinese Consulate Durban	





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