PATHOLOGISTS LANCET KENYA (PLK)
Key to diagnostic excellence
Maabara ya Kisasa

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LAB NO. NPG AFFIX BARCODE LABEL HERE

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Referring Doctor		Copy Doctor		Copy Doctor	

Patient Details

Patient I.D. No.	
Patient Surname	
Patient Initials & First Name	
Patient Date of Birth	D D M M Y Y Y Y Gender F M Age
Hospital / Folio Number	
Patient Cell No.	
Patient Email	

Patient | Guardian Signatures: My signature indicates my understanding of, and my agreement to: comply with the terms of the legal declaration, provide consent for the processing of personal information and the releasing of test results as documented on the back of this form. I give consent for tests and guarantee payment of any amounts.

Signature

Hospital Patient	Y N Fasting Random Routine Urgent
Telephone / Fax Number	
Collection Date	D D M M Y Y Y Y Time HOUR MIN
Venesectionist	Submitted

Person Responsible for Payment of Account

I.D. No.	
Surname & Initials	
First Name	Title
Postal Address	
	C O D E
Telephone No.	(C) (H)
Email	
Employer	(W)
Medical Aid Name	
Med. Aid # Cash Receipt #	
Authorisation #	Dependent Code
Patient Membership Card Verified?	Y N Account No.

Specimen Taken & Received (Refer to the back of this form for the key guide)

B TAKEN REC B TAKEN REC B TAKEN REC C TAKEN REC E TAKEN REC F TAKEN REC FL TAKEN REC H TAKEN REC P TAKEN REC S TAKEN REC S TAKEN REC U TAKEN REC

M TAKEN REC Cel TAKEN REC Asp TAKEN REC SP TAKEN REC T TAKEN REC Sal TAKEN REC BT TAKEN REC * TAKEN REC OTHER: TAKEN REC SPECIFY:

ICD10 Codes:	Clinical | Drug Information:	Other Tests:
		Patient MRI#

SARS-CoV-2 (COVID-19) Request

Test:

C290 ☐ PCR SARS-CoV-2 ☐ SARS-COV-2 IgG Test

Sample Type:

☐ Blood ☐ Sputum ☐ Nasopharyngeal Swab ☐ Throat Swab
☐ Nasal Swab ☐ Tracheal Aspirate ☐ Broncho Alveolar Lavage

Patient Physical Address

County:
Town:
Estate:
Street:

Indication:

☐ General Screening ☐ Recent travel ☐ Contact with a known positive case ☐ Healthcare worker
☐ Outbound Passenger ☐ Hospitality Staff ☐ Quarantined ☐ Truck Driver

Travel History

Country	Date of Departure	Date of Return
	D D M M Y Y Y Y	D D M M Y Y Y Y
	D D M M Y Y Y Y	D D M M Y Y Y Y

Clinical Presentation

Date of onset of symptoms D D M M Y Y Y Y

Symptoms (tick all that apply):

Fever (38°C)	Y N	Shortness of breath	Y N
Cough	Y N	Nausea / Vomiting	Y N
Chills	Y N	Diarrhoea	Y N
Sore Throat	Y N	Other	Y N

Specify _____