

LABORATORY REQUEST FORM FOR COVID-19 TEST

Name : <input style="width: 300px;" type="text"/> R/N : <input style="width: 300px;" type="text"/> I/C No. : <input style="width: 300px;" type="text"/> Sex : <input type="checkbox"/> Male <input type="checkbox"/> Female Age : <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> DOB : <input style="width: 150px;" type="text"/> Nationality : <input style="width: 150px;" type="text"/> Date & Time of specimen : <input style="width: 150px;" type="text"/> Ward/Clinic : <input style="width: 150px;" type="text"/> Hospital : <input style="width: 250px;" type="text"/> Occupation : <input style="width: 150px;" type="text"/> Address : <div style="border: 1px solid black; height: 50px; width: 600px;"></div> Contact No : <input style="width: 150px;" type="text"/>		For Laboratory Use Only Lab No : <div style="border: 1px solid black; height: 100px; width: 300px;"></div>
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Mandatory to fill full address include **postcode, district, and state.*

Please tick ☒ below:

Test requested for SARS-COV2 (Covid-19)

- ☐ RT-PCR
☐ Rapid Molecular Test
☐ Rapid Antigen Test
☐ Rapid Antibody Test

Type of specimens

- ☐ Nasopharyngeal swab (NPS) ☐ Oropharyngeal swab (OPS)
☐ Sputum / ETT
☐ Blood Plain Tube

Clinical Findings:

- Temperature : °C
☐ Asymptomatic screening
☐ Symptomatic screening
 Day of onset
☐ Fever
☐ Sore throat
☐ Dry cough
☐ Vomiting / Nausea
☐ Nasal congestion
☐ Myalgia
☐ Convulsion
☐ Other :
☐ Pre operative screening
 Type of procedure :
 Date of operation :
☐ Pre-admission screening
☐ Healthcare worker
☐ Return to work
☐ Travel to :
☐ Others, please specify :

- ☐ History of close contact with confirmed case.
 Date of exposure :
☐ History of travelling to

 Date of visit :
☐ History of attending mass gathering / event.
 Name of the event :

 Date of the event :

Vaccination status :

- ☐ No
☐ Yes Brand :
☐ Completed 1st dose : .../.../...
☐ Fully vaccinated : .../.../...

Relevant clinical history :

Requesting MO / Clinical Specialist :

Signature & Stamp :

Contact No :

E-mail :

Date :

Note: Kindly contact 04-562 2820 / 2696 a day before sending the specimen.