PATHOLOGISTS

LANCET LABORATORIES

Key to Diagnostic Excellence

Switchboard Numbers:

JHB	0027 (0) 11 358 0800
PTA	0027 (0) 12 483 0100
KZN	0027 (0) 31 308 6500
CPT	0027 (0) 21 673 1700
POLOKWANE	0027 (0) 15 294 0400
RUSTENBURG	0027 (0) 14 597 8500
NELSPRUIT	0027 (0) 13 745 9000

LAB NO. AFFIX BARCODE LABEL HERE

Rev: 015 LAB NO. AFFIX BARCODE LABEL HERE

Referring Doctor **SAMPLE ONLY** | Copy Doctor **SAMPLE ONLY** | Copy Doctor **SAMPLE ONLY**

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. I consent that ICD10 codes may be provided to my medical aid as per statutory requirements on my account. 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

TAKEN REC | Csf 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#

Clinical | Drug Information: | Other Tests:

SARS-CoV-2 ANTIBODY TEST

C291 B SARS-CoV-2 Ab

Previous Positive PCR SARS-CoV-2: Y N

If Yes: Date of PCR: D D M M Y Y Y Y

Previous Symptoms Suggestive of Covid-19: Y N

If Yes: Weeks since symptom onset: ____________ *(weeks)*

SAMPLE ONLY

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