CLINIPATH PATHOLOGY

LABORATORY NO.

COVID 19 COLLECTION FORM

PATIENT INFORMATION

LAST NAME:

FIRST NAME:

DOB: SEX:

ADDRESS:

MOBILE NO:

Medicare No

I IDENTIFY AS: ABORGINAL ☐ TSI ☐ ABORIGINAL & TSI ☐

Symptoms: Yes ☐ No ☐ Local area of concern: Yes ☐ No ☐

Contact with someone in area of concern: Yes ☐ No ☐ Other: ☐

Signature _____ Date _____

COLLECTION DETAILS

COLLECTION CENTRE:

SWAB SITE:

NO. OF SWABS:

COLLECTION DATE & TIME:

COLLECTOR NAME:

DR CODE: W3714 PAYCAT: COVHD