

CORONAVIRUS TEST ORDER

Please, select:

RT PCR – COVID19

Covid19 Antigen test

Name of the patient:.....

Doc No:

Gender male female

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Date of birth:.....

Age:.....

Address:.....

Phone number:.....

Please select if you have the following symptoms:

Temperature/fever	<input type="checkbox"/> yes	<input type="checkbox"/> no
Sore throat	<input type="checkbox"/> yes	<input type="checkbox"/> no
Cough	<input type="checkbox"/> yes	<input type="checkbox"/> no
Shortness of breath	<input type="checkbox"/> yes	<input type="checkbox"/> no

Please select if you suffer from any of the following diseases:

Diabetes	<input type="checkbox"/> yes	<input type="checkbox"/> no
Cardiovascular disease	<input type="checkbox"/> yes	<input type="checkbox"/> no
Cancer	<input type="checkbox"/> yes	<input type="checkbox"/> no
Chronic lung disease	<input type="checkbox"/> yes	<input type="checkbox"/> no

Are you vaccinated? <i>(full doses, not less than 2 weeks ago)</i>	<input type="checkbox"/> yes	<input type="checkbox"/> no
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- I agree that my data will be provided to the RZI in case that the result of the test is positive in order to limit the COVID-19 pandemic.

.....
Date

.....
Signature

BARCODE
