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SARS CoV-2 ANTIBODY REQUEST FORM

PATIENT DETAILS

Forename:

Surname:

Address:

DOB: D D M M Y Y Y Y

Sex : F M

Hospital Number

Hospital Lab Number

SPECIMEN DETAILS

Specimen Type(s): Serum | Plasma

Other:

Specimen Date & Time of collection: D D M M Y Y Y Y H H M M

NB: Please note that both the sample and the test request form must detail the patients name and DOB

CLINICAL DETAILS

Clinical details are essential to inform optimal testing strategy.

Did patient have POSITIVE PCR?: ☐ Yes ☐ No

If Yes:

Date of PCR test: D D M M Y Y Y Y

Admitted to Hospital? ☐ Yes ☐ No

Required O_2? ☐ Yes ☐ No

Recent travel history to: _____

Date Returned: D D M M Y Y Y Y

Date of symptom onset: D D M M Y Y Y Y

Symptom history:

Fever ..... ☐ Sore throat ..... ☐

Myalgia ..... ☐ Respiratory symptoms .. ☐

Diahorrea ..... ☐ Loss of taste/smell: ..... ☐

Asymptomatic ..... ☐

Other: _____

Reason for Investigation:

Close contact with confirmed c ☐ Yes ☐ No

Health Care Worker ☐ Yes ☐ No

Contact History: _____

Seasonal influenza vaccine ☐ Yes ☐ No

Prescription antiviral ☐ Yes ☐ No

Lung disease ☐ Yes ☐ No

(Specify) _____

Diabetes ☐ Yes ☐ No

Cardiovascular disease ☐ Yes ☐ No

Immunosuppression .... ☐ Yes ☐ No

(Specify) _____

Underlying conditions: _____

Other relevant features:

_____

_____

NVRL Contacted ☐ Yes ☐ No

DOCTOR / SURGERY DETAILS/REQUESTING HOSPITAL DETAILS

Name:

Signature:

IMC No:

Date: D D M M Y Y Y Y

Tel:

Surgery Address/Hospital Address/ Stamp

NB: Please note that the sample will not be processed without the address of hospital or surgery