



**CHINESE GENERAL HOSPITAL AND MEDICAL CENTER  
INSTITUTE OF PATHOLOGY  
COVID-19 PCR LABORATORY TEST REQUEST FORM**



Accession No. \_\_\_\_\_

Date: \_\_\_\_\_

CS No.: \_\_\_\_\_

OR No.: \_\_\_\_\_

<b>PATIENT INFORMATION: (PLEASE WRITE LEGIBLY)</b>			
Name: (Last, First, Middle)		Date of Birth: (MM/DD/YYYY)	Age: _____
Room:		Contact no.:	Email Address:
Address: (House/Lot No., Street, Barangay, District, Municipality, Province, Region)			
Employer's Name (Local)	Occupation	Place of Work	Date and Time of Collection:
Specimen Type: Nasopharyngeal swab <input type="checkbox"/> Sputum <input type="checkbox"/> Oropharyngeal swab <input type="checkbox"/> Bronchoalveolar lavage <input type="checkbox"/>			Name of Collector:
Number of family members living in the same house: _____			
<b>REQUESTING UNIT INFORMATION:</b>			
Physicians Name and Signature: _____		Local Government Unit (LGU): _____	
Affiliated Hospital/Clinic: _____		Contact Person: _____	
Tel./Cell No.: _____		Contact: Number: _____	
E-mail add: _____			
<b>Signs and Symptoms Checklist (put a check mark on symptoms experienced within 2 to 14 days)</b> <i>(This list does not include all possible symptoms. DOH/CDC will continue to update this list as we learn more about COVID-19.)</i>			
<input type="radio"/> Fever or chills	<input type="radio"/> Cough	<input type="radio"/> Shortness of breath or difficulty breathing	<input type="radio"/> Fatigue
<input type="radio"/> Muscle or body aches	<input type="radio"/> Headache	<input type="radio"/> New loss of taste or smell	<input type="radio"/> Sore throat
		<input type="radio"/> Congestion or runny nose	<input type="radio"/> Nausea or vomiting
		<input type="radio"/> Diarrhea	

The Laboratory Department shall exert all efforts to issue the test results within 2 days after swabbing for the Regular PCR Test and within 12 hours after swabbing for STAT-PCR. However, due to inadvertence and unforeseen circumstances beyond our control, I understand and fully accept that the hospital shall not be liable for unintended delay in the release of the result of the PCR Test.

I hereby voluntarily waive my rights under the Data Privacy Act of 2012 (R.A. # 10173) in the release of my PCR Test Result to the DOH and its local partners under the IATF Resolution # 22 Series of 2020, dated April 8, 2020, Paragraph C, regarding the mandatory public disclosure of the personal information of positive COVID-19 cases to enhance contact tracing efforts of the government.

I hereby further declare that I indicated any signs and symptoms that I may have in this request form as required by R.A. 11332.

\_\_\_\_\_  
Signature over Printed Name