GOVERNMENT OF WESTERN AUSTRALIA

PathWest LABORATORY MEDICINE WA

ABN 83 469 340 804

COVID-19 INTERNATIONAL TRAVELLER PATHOLOGY REQUEST

Patient to Complete (Print and bring this with you to the Collection Centre)

Surname: _____ *Given Name (s):* _____

Address: _____ *Date of Birth:* _____

Mobile Phone Number: _____ *Email:* _____

Passport Number: _____ *Nationality (from Passport):* _____

Flight Destination: _____ *Date/Time of Travel:* _____

Confidentiality Waiver for COVID-19 Result Authentication

I understand that a third party (eg. Border Force, Immigration, Airlines etc) may contact PathWest to verbally authenticate my COVID-19 test result. I hereby indemnify PathWest and waive any and all of my rights to confidentiality, and consent to PathWest providing my COVID-19 results to any third party by any means that may be required (eg. verbal, email, facsimilie etc).

Patient Signature: _____ Date: _____

Collector to Complete

Collection Details

Collection Centre:_____

Collection Date:_____Time:_____

Swab Site: _____

Collector Name: _____

HE Number:_____

Date Entry Details

Requesting Doctor Code: SM280

Copy to: COVTR

Ward: XLCLINTTV

Test Code: VNCV

Bill Details

MUST be paid at time of test

Fin. Elec: PD

Receipt Number:_____

RCPA The Royal College of Pathologists of Australasia

NATA