COVID19 ANTIBODY TEST FORM

Customer details	Name:
Telephone:	Surname:
Gender:	Post code:
DOB:	Address:

Customers with symptoms

Have you suffered from any COVID19 symptoms?	Y / N

Confirm symptoms below

Sore throat	Shortness of breath	Headache
Loss of sense of smell	Chills or Fever	Achy joints / muscles
Cough with sputum	Vomiting / nausea	Really tired
Congested nose	Dry cough	Stomach disturbance

Date symptoms first appeared	D /M /Y
Are you still suffering symptoms?	Y / N
Date you recovered from symptoms?	D /M /Y

Customers with no previous COVID19 symptoms

Have you had contact with someone suffering COVID19 symptoms?	Y / N
Have you had contact with someone confirmed positive for COVID19?	Y / N
Date you were in contact with person	D /M /Y

PCR Testing

If the customer already had a PCR Viral Test, what was the result?	Positive / Negative / NA

By signing below, I confirm I understand the following

- I understand that a positive result does not guarantee immunity
- I give consent to my details being recorded and stored
- I give consent to my test results to be anonymously shared for COVID19 surveillance purposes
- It has been at least 21 days since I had symptoms or was in contact with someone with symptoms

Name _____ Signature:_____ Date: _____

FOR use by health care professionals

Test result for Customer ID_____ **Date: / /**

Control [positive / negative]	**IgG** [positive / negative]	**IgM** [positive / negative]

pharmadoctor