GREENCITY MEDICAL CENTER
One with nature in bringing quality healthcare

COVID-19 RT-PCR REQUEST FORM

Date (MM/DD/YY): _____

Patient Name: _____
Last Name First Name/s Middle Name

Date of Birth (MM/DD/YY): _____ Age: _____ Gender: ☐Male ☐ Female

Contact No.: _____ Email address: _____

Address:
House/Bldg./Purok/Block No. _____
Street Name, Barangay Name _____
Municipality/City _____
Province _____
Zip Code _____

Reason for the Test:

- ☐ Previously diagnosed with COVID-19 by RT-PCR, please specify testing date: _____
- ☐ Diagnosed as COVID-19 positive by a RAPID TEST
- ☐ CLEARANCE FOR WORK
- ☐ CLEARANCE FOR SURGERY
- ☐ HEALTHWORKER
- ☐ HIGH RISK GROUP (Choose one): ☐ Pregnant ☐ Elderly ☐ with underlying medical conditions
- ☐ SCHEDULED FLIGHT (Choose one): ☐ Within the Country ☐ Outside the Country
- ☐ EXPOSED TO A COVID PATIENT
- ☐ EXHIBIT SYMPTOMS OF COVID-19
- ☐ OTHERS, please specify: _____

CONSENT FORM

I have been informed about COVID-19 (SARS CoV-2) RT-PCR Testing, its benefits and its limitations and hereby certify that all information provided on this form are true and reliable personal information. I also authorize Greencity Medical Center (GMC) to forward any and all information as may be required by law through an appropriate government agency including but not limited to the Department of Health. I also agree to the use of my personal and clinical data by my physician and/or the laboratory for the purposes of auditing, quality assurance and research provided that I remain anonymous and unidentifiable from any reports or publications. Further, I understand that any discomfort felt during the collection of the specimen is unintentional on the part of the allied health professional involved in the process and varies depending on one's pain threshold. In the event that, repeat sample collection may be required, I also give my full consent and shall coordinate and cooperate with GMC on when and where the former shall

be conducted. In compliance to RA 10173, also known as the Data Privacy Act of 2012, I formally grant GMC and its authorized representative/s, permission to scrutinize two (2) of my valid IDs and take a photo of myself at the PCR drive thru for documentation purposes.

_____

Patient's signature over printed name/Date