Medical Center ‘‘SELENA-L‘‘ EOOD
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SARS-CoV-2 PCR REQUEST FORM

PATIENT INFORMATION

Name, middle name, surname: .....

Personal ID | | | | | | | | | | |

Date of birth: .....

Sex : ☐ male ♂ ☐ female ♀

Telephone number: .....

Home address:.....

☐ **Need for a certificate in English**

- Name, middle name and surname in Latin, according to the identity document: .....
- Number of the identity document: .....

○ Without contact ○ Contact with people who have travelled abroad ○ Contact with a confirmed case of SARS-Cov-2 ○ Contact with a suspected case of SARS-Cov-2 ○ Without symptoms ○ With symptoms	Sample was taken by: Sample is received from: The test is conducted by:

TYPE OF SAMPLE - nasopharyngeal secretion

CLINICAL AND EPIDEMIOLOGICAL INFORMATION

Clinical details ○ High temperature ○ Cough ○ Shortness of breath/difficulty breathing ○ Sore throat ○ Clinical information for pneumonia /ARDS ○ Radiological information for pneumonia /ARDS Onset of symptoms:	Travelled abroad in the last 14 days? If yes: In which country? ..... Date of return to Bulgaria: Seasonal flu vaccine? ☐ YES ☐ NO Concomitant diseases: (Please specify)

Date of sample collection: Time: Patient signature: