Łukasiewicz PORT Polish Center for Technology Development	**Order of laboratory test at the Medical Diagnostic Laboratory**

Order barcode:

Patient data (please fill in **capital letters)**

Name:		Surname:														
Date of birth:		PESEL No:*												Sex:	F	M

(day/ month/ year)

*In case of the lack of PESEL No or in case of other requirements , e.g. when crossing the border, the name and numer of another identity document:

Type of document:		No:	
Citizenship:			
Place of residence:	Zip code: _ _ - _ _ _ _	City:	
	Street & House No/Apartment No:		
Contact details:	Phone No:		

Filling the above data is obligatory for acception an order for diagnostic test. Preparred on the basis of the current Regulation of the Minister of Health on quality standards for medical diagnostic and microbiological laboratories as well as other regulations in the field of medical documentation.

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1. Principal: ☐ patient/☐ legal guardian of the patient/☐ employer/☐ medical facility/ doctor

(invoice data – company name, proincipal data or individual patient data)

Name:

Tax ID:
Phone/ e-mail:

Ordering doctor personal stamp

2. Type of the test ordered (please select with X)

☐ **SARS-CoV-2 Antigen** – rapid qualitative test

☐ **Anti SARS-CoV-2 antibodies IgG class** – quantitative test

Test offer - anti SARS-CoV-2 antibodies IgG class			
Standard test ☐	Special offer ☐	Package - 2 tests ☐	Package - 3 tests ☐

☐ **RT-qPCR SARS-CoV-2 test** – PCR molecular/genetic test

Test offer - test RT-qPCR SARS-CoV-2			
Standard test ☐	Family package 2+1 ☐	Family package 2+2 ☐	Group - __ people ☐

3. Comments:

Test execution type: ☐ **EXPRESS /** ☐ **STANDARD**		Result in English ☐ **YES /** ☐ **NO**
VAT invoice** ☐	Personal invoice** ☐	Receipt ☐

**the data for the invoice sholud be included in the point 1 of the form order (principal)

4. Relevant clinical data of the patient:

Chronic diseases: .....

Drugs taken permanently:.....

5. Testing for infectious diseases:

Do you have any symptoms of an infection? ☐ **YES /** ☐ **NO**

Type of symptoms, how long have they been occuring:.....

.....

Declarations necessary for the order execution

☐ **YES /** ☐ **NO** I have read the information clause regarding the protection of personal data for the purposes of ordering tests, provided me by the Medical Diagnostic Laboratory when accepting the test ordrer. I confirm that I know I can read the same clause at any time via the website www.port.org.pl/pl/dane-osobowe/

☐ **YES /** ☐ **NO/** ☐ **NOT APPLICABLE** In the case of PCR tests, I agree to the isolation of genetic material and the performamnce of the molecular test indicated on the order form for diagnostic purposes. I have obtained the information about the diagnostic significance of the ordered test. Lack of consent may make it impossible to conduct the examination.

☐ **YES /** ☐ **NO** I agree for the material collection (swab, blood) in order to carry out the selected diagnostic test and I have been informed about the method of collection

☐ **YES /** ☐ **NO** I am interested in participating in the future research projects aimed at broadening the knowledge of the underlying causes of diseases. I hereby give my consent for the representative of the Łukasiewicz PORT Research Network to contact me in order to present the conditions for participation in future scientific research.

The patient has the right to submit a compliant regarding the manner of executing the order up to 14 days from the receit of the report, by e-mail or by phone. Details are available on the website of Łukasiewicz – PORT www.port.org.pl.
In case of patients under the age of 16, consent is given by the legal representative/ actual guardian of the patient, between 16 and 18, by the patient and/ or his /her legal representative/ actual guardian, over 18 – the patient him-/herself.

Legal guardian of the patient/ actual guardian of the patient:

.....

(date, legible signature – name and surname)

Patient:

.....

(date, legible signature – name and surname)

To be completed by an employee of the Collection Point

Type of material collected:

☐ swab, collection place: throat and/or nose / nosopharyngeal swab

☐ blood: ..... ☐ plasma, ☐ serum

☐ other: .....

Date and time of collecting the material for testing: _ _ /_ _ / _ _ _ _ _ _ : _ _

.....

Name and surname of the person collecting the material:.....

To be completed by an employee of the Medical Diagnostic Laboratory

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Is the material useful for testing? ☐ YES / ☐ NO because of:.....

Date and time of receiving the material at the laboratory: _ _ /_ _ / _ _ _ _ _ _ : _ _

Comments: .....

Lab Staff member: .....
(signature)