COVID-19
Surge Testing Collection Form

Western Diagnostic PATHOLOGY

Laboratory number

Patient Information (Patient to complete in BLOCK LETTERS)

Last Name:											
First Name:											
Date of Birth:							**Sex:**				
Mobile No:											
Address:											

I identify as (circle)	**Aboriginal**	**Torres strait Islander (TSI)**	**Aboriginal & TSI**

Flu-like symptoms:	**YES**				**No**			
Visited known area of concern:	**YES**				**No**			
If Yes, provide location and state or territory (circle).	**WA**	**NT**	**SA**	**VIC**	**NSW**	**QLD**	**TAS**	**ACT**

Name & Address of your GP (N/A if not known)	

You will be advised of a negative test by SMS within 24 hours from the time of collection.
To Access our Privacy Policy visit **www.wdp.com.au/privacy.**

Collection Information

Collection Location (circle) Print Location here if not stated	**Joondalup DT**	**Myaree DT**	**Armadale DT**	**Mt Hawthorn DT**
	Mandurah DT	**Midland DT**	**Duncraig**	**Rockingham**
	Myaree	**Albany**	**Bunbury**	
Swab Site	**Throat and Deep Nasal x 1**			
Collection Date & Time (Stamp)				
Doctor Code	**DMC1A**			
Pay Category	**Commercial Account DHWA**			