лабораторија avicena

ПЗУ АВИЦЕНА ЛАБОРАТОРИЈА
СПЕЦИЈАЛИСТИЧКА ДИЈАГНОСТИЧКА ЛАБОРАТОРИЈА

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PATIENT QUESTIONARRY for COVID-19 testing

Please fill in this form. Please fill in all the required fields.

Name and surname: _____

Personal ID number: _____

Address:_____**Municipality:**_____**City:**_____

Phone No.: _____**E-mail:**_____

1. DO YOU FEEL ANY OF THE FOLLOWING SYMPTOMS AT THE MOMENT?

A. Fever (high body temperature)

Б. Sore throat, cough, difficulty breathing

B. Fatigue

2. DID YOU HAVE PREVIOUS CONTACT WITH CONFIRMED/SUSPECTED PERSON WITH COVID-19?

A. YES **B. NO**

3. DID YOU HAVE A PREVIOUS COVID-19 TEST? If yes, which type of test?

A. **YES** _____ **B. NO**

I responsibly declare that the given data is correct.
With my signature I confirm that the results can be sent to the above e-mail address.

Signature:_____ Date:_____

Thank you for your cooperation.