

COVID-19 Testing Unit - Registration Form

1. Personal data

Name		first name	Gender <input type="checkbox"/> f <input type="checkbox"/> m
Date of birth	Cell phone number (please write legibly!)	Health insurance <input type="checkbox"/> statutory <input type="checkbox"/> private	
Street, house number		POSTAL-	Place of residence

2. Professional data

Employer	Workplace (e.g. ward/ KUM staff: campus (INN/GH))
Professional group	

3. Exposure (within the last 14 days)

Close contact to confirmed case <input type="checkbox"/> Employees <input type="checkbox"/> Patient / Client <input type="checkbox"/> private environm <input type="checkbox"/> other <input type="checkbox"/> not applicable	
Other exposure (e.g. stay in designated COVID-19 risk area)	
Earliest possible date of exposure (if known)	Latest possible date of exposure (if known)

4. Current symptoms

Are there any current symptoms? <input type="checkbox"/> no <input type="checkbox"/> yes, since (date):	
if yes: What are the current symptoms? <input type="checkbox"/> Fever <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Sore throat <input type="checkbox"/> Runny nose <input type="checkbox"/> loss of sense of smell and/or taste <input type="checkbox"/> Headache <input type="checkbox"/> others: _____	

5. Vital parameters (to be taken and filled in CTU staff)

Temperature _____	Oxygen saturation: _____	Pulse: _____
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6. Results release

The result of the test carried out will be communicated to the occupational health service responsible for you (if applicable). In addition, each patient receives his or her result promptly by SMS (please check your mobile phone number!).

* I hereby confirm that I have read the "Patient information on data protection". I agree to the "Treatment Contract for Outpatient Treatment", the "Declaration of Consent on Data Protection" and the "Contract on the Use of Outpatient Private Medical Services" (the latter only for private patients) in the form available as a pdf document on the homepage of the Tropical Institute Munich (all documents are available at www.tropinst.med.uni-muenchen.de).

* I am aware that the billing of the diagnostics is done by my statutory or private health insurance company. The Tropical Institute explicitly does not clarify whether this is a competence of the professional association.

I agree to be contacted by phone for SARS-CoV-2 specific study purposes if necessary:

yes no

Date: _____ Signature (in case of minors, signature of legal guardian) ____

Name:

First name:

Date of birth

INTERNAL use (please DO NOT fill in):

Test result: **positive** **negative**

Initial testing: yes no

if no, when: first test done on ____ . ____ . ____

Follow-up test no. ____

Testing after re-exposure

Result notification: Patient

Health Authority

Occupational health