Shingles Test Request Form

Patient Details:

Full Name: John A. Doe

Date of Birth: January 1, 1970 **Age:** 53

Gender: Male

Address: 23 Wellness Ave, Health City, State, 45678

Contact Number: (123) 456-7890

Email Address: johndoe@email.com

Referring Physician/Healthcare Provider Details:

Name: Dr. Jane B. Smith

Contact Number: (321) 098-7654

Email Address: dr.janesmith@email.com

Hospital/Clinic: Health City Medical Center

Clinical Information:

Date of Onset of Symptoms: September 20, 2023

1. **Presenting Symptoms:** (Please tick as appropriate)
   - ☑ Pain
   - ☑ Rash
   - ☑ Itching
   - ☐ Fever
   - ☑ Fatigue
   - ☑ Sensitivity to Touch
   - ☐ Headache
   - ☐ Others (please specify): _____
2. **Site of Rash:** Left side of the chest and back
3. **Previous Episodes of Shingles:** ☐ Yes ☑ No
   - If yes, please provide details: N/A
4. **Underlying Health Conditions:** (e.g. Immunocompromised)
   N/A

Test Details:

1. **Type of Test Requested:**
   - [x] Varicella Zoster Virus (VZV) PCR
   - [ ] VZV Antibody Testing
   - [ ] Tzanck Smear
   - [ ] Other (please specify): _____
2. **Preferred Method of Result Notification:**
   - [x] Phone Call
   - [ ] Email
   - [ ] SMS
   - [ ] Others: _____

Consent:

I hereby give my consent to undergo the shingles test as described above. I understand the nature of the test, and I am aware that no test is complete without risk. I also consent to the use of my personal information for purposes related to this test.

Patient's Signature: John A. Doe

Date: September 28, 2023

Referring Physician/Healthcare Provider's Signature: Dr. Jane B. Smith

Date: September 28, 2023

Note: Please ensure that all the details provided are accurate to avoid any delays or issues with the testing process. The results of the test will be communicated as per the preferred method of notification indicated above.