Shingles Test Request Form

Patient Details:	
Full Name:	
Date of Birth:	Age:
Gender:	
Address:	
Contact Number:	
Email Address:	
Referring Physician/Healthcare P	Provider Details:
Clinical Information:	
Date of Onset of Symptoms:	
1. Presenting Symptoms: (Pleas	e tick as appropriate)
☐ Pain	
Rash	
Itching	
☐ Fever	
☐ Fatigue	
Sensitivity to Touch	
Headache	
Others (please specify):	
2. Site of Rash:	
3. Previous Episodes of Shingles	
If yes, please provide details	s:

4. Underlying Health Conditions: (e.g. Immunocompromised)

Test Details:
1. Type of Test Requested:
□ Varicella Zoster Virus (VZV) PCR
□ VZV Antibody Testing
☐ Tzanck Smear
Other (please specify):
2. Preferred Method of Result Notification:
☐ 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:
Date:
Referring Physician/Healthcare Provider's Signature:
Date:

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.