AAR Hospital

AAR COVID-19 TEST FORM

NAME	
CARE RECIPIENT NO.	
AGE/DOB	
ID/PASSPORT NO.	
GENDER	
PHONE. NO	
EMAIL ADDRESS	
OCCUPATION	
NATIONALITY	
COUNTY OF RESIDENCE	
SUB COUNTY/VILLAGE/ESTATE	
REASON FOR TESTING	
TYPE OF CASE(INITIAL/REPEAT)	
HISTORY OF TRAVEL <14 DAYS	
TRAVEL FROM	
CONTACT WITH CASE	
CONFIRMED CASE NAME	
QUARANTINE/HOSPITAL NAME	
HAVE SYMPTOMS? LIST THEM HERE	
DATE OF ONSET OF SYMPTOMS	
VACCINATION STATUS	
SAMPLE TYPE	
RESULTS	
ACTION TO BE TAKEN	

FILLED BY: _____ DATE: ☐☐ ☐☐☐☐ ☐☐☐☐