

Shingles Test Request Form

Patient Details:

Full Name: _____

Date of Birth: _____ Age: _____

Gender: _____

Address: _____

Contact Number: _____

Email Address: _____

Referring Physician/Healthcare Provider Details:

Name: _____

Contact Number: _____

Email Address: _____

Hospital/Clinic: _____

Clinical Information:

Date of Onset of Symptoms: _____

1. Presenting Symptoms: (Please tick as appropriate)

- ☐ Pain
- ☐ Rash
- ☐ Itching
- ☐ Fever
- ☐ Fatigue
- ☐ Sensitivity to Touch
- ☐ Headache
- ☐ Others (please specify): _____

2. Site of Rash: _____

3. Previous Episodes of Shingles: ☐ Yes ☐ No

- If yes, please provide details: _____

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.