

CONFIDENTIAL | COVID-19 SWABBING REFERRAL FORM

Key Workers only – return to elft.keyworkertests-bl@nhs.net

Date: _____ Symptoms: Yes No

Key Workers Name: _____

Sex: M F Date of Birth: _____ Age: _____

Ethnicity: _____ GP Name & Address: _____

Home Address: _____

NHS Number: _____ Car Reg Number: _____

Tel: _____ Email: _____

Mobile telephone number for results to be sent to (SMS messages are preferred method of communicating results)

A separate referral form must be completed should you need others in your household tested

Referring Organisation - (Key Worker's Employer)

Company Name: _____

Company Address: _____

Job Title: _____

Office Use Only

Appointment Time: _____ Appointment Date: _____

Systemone: _____ Ice form: _____ Label: _____