**COVID-19 TESTS – ORDINACE Liběchov s.r.o.**

**INSTITUTE OF ANIMAL PHYSIOLOGY AND GENETICS LIBĚCHOV**

*The tested patient fills in in capital letters*:

Name and Surname: ………………… …………………………

 *(Name) (Surname)*

Personal Identification Number (number of the health insurance card):

Nationality:

Health Insurance Company:

Address:

Phone Number:

E-mail:

I have COVID-19 symptoms (*underline the appropriate*)

NO YES (cough, fever, lost of taste/smell, joint ache, diarrhea)

I agree with the processing of data for sending the results to the IHIS (**Institute of Health Information and Statistics of the Czech Republic)** system and for the requirements of the tested place and healt insurance company, which pays me for this test and IAPG CAS. This consent is the necessary condition of testing

*……………………………………………*

*(Signature of the tested patient)*

The results will be communicated to you by SMS, will be entered into the IHIS system and archived in the surgery.

*---------------------------------------------------------------------------------------------------------------*

*The wokplace fills in*:

Číslo:

Datum:

Čas založení vzorku:

Čas odečtení vzorku:

Výsledek: