South Tyneside COVID-19 Key Worker Testing Referral Form

Primary Care Staff Testing Hub

Stanhope Parade

Gordon Street

South Shields

NE33 4JP

Date: **DD/MM/YYYY**

|  |  |
| --- | --- |
| Referrer Name |  |
| Referring Organisation |  |
| Organisation Contact Number |  |
|  | |
| Title | Mr  Mrs  Miss  Ms |
| Staff Member Name |  |
| Staff Members Registered GP |  |
| Date of Birth(if requesting test for named person above) |  |
| Contact Mobile Number |  |
| Do you have access to private transport | Yes  No |
| Symptomatic | Isolating |
| Name of family member affected if isolating |  |
| Family Members Registered GP |  |
| Date of Birth(if requesting test for named person above) |  |
| Consent to test (or family member consent if family member to be tested) | Yes  No |
| Consent to send result directly to GP? | Yes  No |
| Date Isolation Began |  |
| Date Isolation Due to End |  |