**PRO FORMA – COVID-19 TESTING (NON-ACUTE SECTOR)**

**Please read the procedures appended to this form and ensure all of the required information is entered.**

|  |  |
| --- | --- |
| **Provider Organisation and Contact email address** |  |
| **Date Submitted:** |  |
| **Time Submitted:** |  |
| **Number of Persons Listed on this Form:** |  |
| **Please send completed form to:** | **Place based Director of Operations** |
| **For ICS Quality Team to complete - Date / Time received:** |  |
| **For ICS Quality Team to complete - Date / Time sent to Test provider:** |  |

**The following is your list of staff / index contacts being put forward for approval for testing. The information requested below is essential in order for testing to be approved and arranged. If you have more than 5 persons to nominate, please use copy and paste to create more tables.**

|  |  |  |
| --- | --- | --- |
| **PERSON 1** | | |
| **Title (e.g. Mr, Mrs, Ms):** | |  |
| **Name:** | |  |
| **Date of Birth:** | |  |
| **Home Address:** | |  |
| **Mobile Number:** | |  |
| **NHS Number (if known):** | |  |
| **Is this a staff member or a person with whom the staff member is living with who is currently symptomatic?** | |  |
| **Site they normally work on (if staff):** | |  |
| **Department, Team or Specialty they work in (if staff):** | |  |
| **Time and date of their first symptoms:** | |  |
| **Why are they a priority for testing? (i.e. what is their critical function?). Please be specific:** | |  |
| **For ICS Quality Team to complete** | | |
| Recommendation for testing |  | |

|  |  |  |
| --- | --- | --- |
| **PERSON 2** | | |
| **Title (e.g. Mr, Mrs, Ms):** | |  |
| **Name:** | |  |
| **Date of Birth:** | |  |
| **Home Address:** | |  |
| **Mobile Number:** | |  |
| **NHS Number (if known):** | |  |
| **Are they a Staff Member or a person with whom the staff member is living with who is currently symptomatic?** | |  |
| **Site they normally work on (if staff):** | |  |
| **Department, Team or Specialty they work in (if staff):** | |  |
| **Time and date of their first symptoms:** | |  |
| **Why are they a priority for testing? (i.e. what is their critical function?) Please be specific:** | |  |
| **For ICS Quality Team to complete** | | |
| Recommendation for testing |  | |

|  |  |  |
| --- | --- | --- |
| **PERSON 3** | | |
| **Title (e.g. Mr, Mrs, Ms):** | |  |
| **Name:** | |  |
| **Date of Birth:** | |  |
| **Home Address:** | |  |
| **Mobile Number:** | |  |
| **NHS Number (if known):** | |  |
| **Are they a Staff Member or a person with whom the staff member is living with who is currently symptomatic?** | |  |
| **Site they normally work on (if staff):** | |  |
| **Department, Team or Specialty they work in (if staff):** | |  |
| **Time and date of their first symptoms:** | |  |
| **Why are they a priority for testing? (i.e. what is their critical function?) Please be specific:** | |  |
| **For ICS Quality Team to complete** | | |
| Recommendation for approval |  | |

|  |  |  |
| --- | --- | --- |
| **PERSON 4** | | |
| **Title (e.g. Mr, Mrs, Ms):** | |  |
| **Name:** | |  |
| **Date of Birth:** | |  |
| **Home Address:** | |  |
| **Mobile Number:** | |  |
| **NHS Number (if known):** | |  |
| **Are they a Staff Member or a person with whom the staff member is living with who is currently symptomatic?** | |  |
| **Site they normally work on (if staff):** | |  |
| **Department, Team or Specialty they work in (if staff):** | |  |
| **Time and date of their first symptoms:** | |  |
| **Why are they a priority for testing? (i.e. what is their critical function?) Please be specific:** | |  |
| **For ICS Quality Team to complete** | | |
| Recommendation for approval |  | |

|  |  |  |
| --- | --- | --- |
| **PERSON 5** | | |
| **Title (e.g. Mr, Mrs, Ms):** | |  |
| **Name:** | |  |
| **Date of Birth:** | |  |
| **Home Address:** | |  |
| **Mobile Number:** | |  |
| **NHS Number (if known):** | |  |
| **Are they a Staff Member or a person with whom the staff member is living with who is currently symptomatic?** | |  |
| **Site they normally work on (if staff):** | |  |
| **Department, Team or Specialty they work in (if staff):** | |  |
| **Time and date of their first symptoms:** | |  |
| **Why are they a priority for testing? (i.e. what is their critical function?) Please be specific:** | |  |
| **For ICS Quality Team to complete** | | |
| Recommendation for approval |  | |

Please add additional names as required