

COVID-19 Virus Test Requisition

| | |
|--------------------------------------|-----------|
| For laboratory use only | |
| Date received: yyyy / mm / dd | PHOL No.: |

ALL Sections of this form must be completed at every visit

1 - Submitter Lab Number (if applicable):

Ordering Clinician (required)
 Surname, First Name:
 OHIP/CPSO/Prof. License No:
 Address:
 Postal code:
 Phone: (###) ###-#### Fax: (###) ###-####

cc Hospital Lab (for entry into LIS)
 Hospital Name:
 Address (if different from ordering clinician):
 Postal Code:
 Phone: (###) ###-#### Fax: (###) ###-####

cc Other Clinician or ICP:
 Surname, First name:
 OHIP/CPSO/Prof. License No.:
 Address:
 Postal code:
 Phone: (###) ###-#### Fax: (###) ###-####

2 - Patient Information

| | |
|--------------------------------------|--------------------------------------|
| Health Card No.: | Medical Record No.: |
| Last Name: | |
| First Name: | |
| Date of Birth: yyyy / mm / dd | Sex: M F |
| Address: | |
| Postal Code: | Patient Phone No.: (###) ###-#### |
| Investigation / Outbreak No.: | |

3 - Travel History

Travel to:

| | |
|---------------------------------------|---------------------------------------|
| Date of Travel: yyyy / mm / dd | Date of Return: yyyy / mm / dd |
|---------------------------------------|---------------------------------------|

4 - Exposure History

| | | |
|---|-----|----|
| Exposure to probable, or confirmed case? | Yes | No |
| Exposure details: | | |
| Date of symptom onset of contact: yyyy / mm / dd | | |

5 - Test(s) Requested

| | |
|----------------|---|
| COVID-19 Virus | Respiratory viruses check ONLY if required for hospitalized patient or those in group setting) |
|----------------|---|

7 - Patient Setting / Type

| | | |
|---|--|------------------------------|
| Assessment Centre | Family doctor / clinic | Outpatient / ER not admitted |
| Only if applicable, indicate the group: | | |
| Healthcare worker | Institution / all group living settings | |
| Inpatient (hospitalized) | Confirmation (for use ONLY by a COVID testing lab). Enter your result (NEG/POS/ or IND) | |
| Inpatient (ICU / CCU) | | |
| First Nations / Inuit | | |
| Unhoused / shelter | For clearance of disease | |
| ER - to be hospitalized | Other (Specify): | |
| Deceased / Autopsy | | |

6 - Specimen Type (check all that apply)

Specimen Collection Date: **yyyy / mm / dd (required)**

| | |
|--------------------|---------------------|
| NPS in UTM | If possible: |
| Throat Swab in UTM | BAL |
| Other (Specify): | Sputum |

8 - Clinical Information

| | |
|--|-------------|
| Asymptomatic | Symptomatic |
| Date of symptom onset: yyyy / mm / dd | |
| Fever / temperature, if known: | Pneumonia |
| | Cough |
| Pregnant / also check if in labour: | Sore Throat |
| Other (specify): | |

CONFIDENTIAL WHEN COMPLETED
 The personal health information is collected under the authority of the Personal Health Information Protection Act, s.36(1)(c)(iii) for the purpose of clinical laboratory testing. If you have questions about the collection of this personal health information please contact the PHO laboratory Manager of Customer Service at 416-235-6556 or toll free 1-877-604-4567. Form No. F-SD-SCG-4000 (04/13).