Shared Living Centres (LTCH) COVID-19 Test Requisition

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: (###) ###-####

Enter the name and license number for the clinician ordering the test, for LTC and other congregant living centres this information can be prepopulated acceptable values in reference https://www.ehealthontario.on.ca/en/practitionerextract/request

The shared living facility address of the patient a minimum of the "COVID-19 Mobile Testing Unique ID" from the Shared Living Centre table https://www.ehealthontario.on.ca/images/uploads/support/Shared-Living_AssessCtr_COVID-19.xlsx plus POSTAL CODE must be included. Phone Number for the Shared Living Centre should be provided.

Event Specific OUTBREAK Number/ Investigation number needs to be provided

Provide details if available on Travel and Exposure History

Primary Care Doctor should be included here so they can be authorized to receive results and be notified through HRM if possible
acceptable values in reference https://www.ehealthontario.on.ca/en/practitionerextract/request

Health Card Number is required for all patients who have one, MRN as alternative

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
- ☐ Inpatient (hospitalized)
- ☐ Inpatient (ICU/CCU)
- ☐ First Nations / Inuit
- ☐ Unhoused / shelter
- ☐ ER - to be hospitalized
- ☐ Deceased / Autopsy
- ☐ Institution / all group living settings
- ☐ Confirmation (for use **ONLY** by a COVID testing lab). Enter your result (NEG/POS/or IND)
- ☐ For clearance of disease
- ☐ Other (Specify):

Patient Location information needs to be captured to support the organizing and reporting of data, for which setting the patient\worker was seen at.

*This data **must be captured** discretely from the Shared Living Centre reference table available at https://www.ehealthontario.on.ca/images/uploads/support/Shared-Living_AssessCtr_COVID-19.xlsx (Enter the COVID-19 Mobile Testing Unique ID e.g. LTC-1001 in the "Other" box and if possible **pre-printed on the requisition form.***

6 - Specimen Type (check all that apply)

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

- ☐ NPS in UTM
- ☐ Throat Swab in UTM
- ☐ Other (Specify):

If possible:

- ☐ BAL
- ☐ Sputum

Specimen Collection Date must be entered

8 - Clinical Information

- ☐ Asymptomatic
- ☐ Symptomatic

Date of symptom onset: yyyy / mm / dd

- ☐ Fever / temperature, if known:
- ☐ Pregnant / also check if in labour: ☐
- ☐ Other (specify):
- ☐ Pneumonia
- ☐ Cough
- ☐ Sore Throat

Enter patient symptoms and date of onset.