Public Health Ontario | Santé publique Ontario

COVID-19 and Respiratory 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: Dr. Janet DeMille, Medical Officer of Health

OHIP/CPSO/Prof. License No: 71213

Name of clinic/ facility/health unit: Thunder Bay District Health Unit, Contact: Infectious Disease Program (IDP)

Address: 999 Balmoral Street Thunder Bay, ON

Postal code: P7B 6E7

Phone: (807) 625-8318

Fax: (807) 625-4822

cc ☐ **Hospital Lab (for entry into LIS)**

Hospital Name:

Address (if different from ordering clinician):

Postal Code:

Phone:

Fax:

cc ☐ **Other Authorized Health Care Provider:**

Surname, First name:

OHIP/CPSO/Prof. License No.:

Name of clinic/ facility/health unit:

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 or Outbreak No.: 2262-

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
● COVID-19 Virus AND Respiratory Viruses

6 - Specimen Type (check all that apply)

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

- ☑ NPS
- ☐ Throat Swab
- ☐ Saliva (Swish & Gargle)
- ☐ Deep or Mid-turbinate Nasal Swab
- ☐ Throat + Nasal
- ☐ Saliva (Neat)
- ☐ BAL
- ☐ Anterior Nasal (Nose)
- ☐ Oral (Buccal) + Deep Nasal
- ☐ Other (Specify):

7 - Patient Setting / Type

- ☐ Assessment Centre
- ☐ Family doctor / clinic
- ☐ Outpatient / ER not admitted

Only if applicable, indicate the group:

- ☐ ER - to be hospitalized
- ☐ Deceased / Autopsy
- ☐ Healthcare worker
- ☑ Institution / all group living settings
- ☐ Inpatient (Hospitalized)

Facility Name:

- ☐ Inpatient (ICU / CCU)
- ☐ Remote Community
- ☐ Unhoused / Shelter
- ☐ Other (Specify):
- ☐ Confirmation (for use **ONLY** by a COVID testing lab). Enter your result (NEG / POS / or IND):

8 - COVID-19 Vaccination Status

○ Received all required doses >14 days ago
○ Unimmunized / partial series / ≤14 days after final dose
○ Unknown

9 - Clinical Information

- ☐ Asymptomatic
- ☐ Symptomatic
- ☐ Fever
- ☐ Pneumonia
- ☐ Cough
- ☐ Sore Throat
- ☐ Pregnant
- ☐ Other (Specify):

Date of symptom onset (yyyy/mm/dd):

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 (21/07/22).

Ontario