

For laboratory use only

Date received: yyyy / mm / dd

PHOL No.:

COVID-19 Virus Test Requisition

ALL Sections of this form must be completed at every visit

1 - Submitter		2 - Patient Information	
Name Address City & Province Postal Code		Health Card No.:	Medical Record No.:
Submitter lab no. number (if applicable):		Last Name:	
Clinician initial / Surname and OHIP / CPSO Number		First Name:	
Telephone: (###) ###-####	Fax: (###) ###-####	Date of Birth: yyyy / mm / dd	Sex: M F
cc Doctor/Qualified Health Care Provider information		Address:	
Name:		Postal Code:	Patient Phone No.: (###) ###-####
Lab/Clinic Name:		3 - Travel History	
CPSO Number:		Travel to:	
Telephone: (###) ###-####	Fax: (###) ###-####	Date of Travel: yyyy / mm / dd	Date of Return: yyyy / mm / dd
Address:		4 - Exposure History	
Postal Code:		Exposure to PUI, probable, or confirmed case? Yes No	
5 - Test(s) Requested		Exposure details:	
COVID-19 Virus		Date of return of contact (if travelled): yyyy / mm / dd	
Does this patient meet the provincial definition of person under investigation (PUI)? Yes No		Date of symptom onset of contact: yyyy / mm / dd	
6 - Specimen Type (check all that apply)		8 - Clinical Information	
Specimen Collection Date: yyyy / mm / dd		Date of symptom onset: yyyy / mm / dd	
If possible:		Fever Temperature, if known:	
NPS in UTM	BAL	Cough	
Throat Swab in UTM	Sputum	Sore Throat	
7 - Patient Setting		Pneumonia	
Physician office/clinic	Inpatient (ICU)	Other (Specify):	
ER (not admitted)	Institution	9 - Will the Patient Be Hospitalized?	
Inpatient (ward)		Yes No	

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 (03/20).