

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: 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.:																	
cc Hospital Lab (for entry into LIS) Hospital Name: Address (if different from ordering clinician): Postal Code: Phone: Fax:			3 - Travel History Travel to: Date of Travel (yyyy-mm-dd): Date of Return (yyyy-mm-dd):																	
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:			4 - Exposure History Exposure to probable, or confirmed case? Yes No Exposure details: Date of symptom onset of contact (yyyy-mm-dd):																	
6 - Specimen Type (check all that apply)			5 - Test(s) Requested																	
Specimen Collection Date (yyyy-mm-dd): (required) <table border="0"> <tr> <td>NPS</td> <td>Throat Swab</td> <td>Saliva (Swish & Gargle)</td> </tr> <tr> <td>Deep or Mid-turbinate Nasal Swab</td> <td>Throat + Nasal</td> <td>Saliva (Neat)</td> </tr> <tr> <td></td> <td>BAL</td> <td>Anterior Nasal (Nose)</td> </tr> <tr> <td>Oral (Buccal) + Deep Nasal</td> <td colspan="2">Other (Specify):</td> </tr> </table>			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):		<table border="0"> <tr> <td>COVID-19 Virus</td> <td>Respiratory Viruses</td> <td>COVID-19 Virus AND Respiratory Viruses</td> </tr> </table>			COVID-19 Virus	Respiratory Viruses	COVID-19 Virus AND Respiratory Viruses
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8 - COVID-19 Vaccination Status <table border="0"> <tr> <td>Received all required doses >14 days ago</td> <td>Unimmunized / partial series / ≤14 days after final dose</td> <td>Unknown</td> </tr> </table>			Received all required doses >14 days ago	Unimmunized / partial series / ≤14 days after final dose	Unknown	7 - Patient Setting / Type <table border="0"> <tr> <td>Assessment Centre</td> <td>Family doctor / clinic</td> <td>Outpatient / ER not admitted</td> </tr> </table> 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) Confirmation (for use ONLY by a COVID testing lab). Enter your result (NEG / POS / or IND): Remote Community Unhoused / Shelter Other (Specify):			Assessment Centre	Family doctor / clinic	Outpatient / ER not admitted									
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9 - Clinical Information <table border="0"> <tr> <td>Asymptomatic</td> <td>Fever</td> <td>Pregnant</td> </tr> <tr> <td>Symptomatic</td> <td>Pneumonia</td> <td>Other (Specify):</td> </tr> <tr> <td>Date of symptom onset (yyyy-mm-dd):</td> <td>Cough</td> <td></td> </tr> <tr> <td></td> <td>Sore Throat</td> <td></td> </tr> </table>			Asymptomatic	Fever	Pregnant	Symptomatic	Pneumonia	Other (Specify):	Date of symptom onset (yyyy-mm-dd):	Cough			Sore Throat		CONFIDENTIAL WHEN COMPLETED The personal health information is collected under the authority of the <i>Personal Health Information Protection Act</i> , 2004, s.36 (1)(c)(iii) for the purposes specified in the <i>Ontario Agency for Health Protection and Promotion Act</i> , 2007, s.1 including clinical laboratory testing and public health purposes. If you have questions about the collection of this personal health information please contact the PHO's Laboratory Customer Service at 416-235-6556 or toll free 1-877-604-4567. F-SD-SCG-4000 version 006.1 (August 2024).					
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