Public Health Ontario | Santé publique Ontario

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: Rea, Elizabeth

OHIP/CPSO/Prof. License No: 59812

Name of clinic/ facility/health unit: Toronto Public Health

Address: 850 Coxwell Avenue, 1st Floor, East York, Ontario
Postal code: M4C 5R1

Phone: (416) 338-7492
Fax: (416) 696-3477

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.: 3895-2021-

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 a group setting).

6 - Specimen Type (check all that apply)

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

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

7 - Patient Setting / Type

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

Only if applicable, indicate the group:

☐ ER - to be hospitalized
☐ Healthcare worker
☐ Inpatient (Hospitalized)
☐ Inpatient (ICU / CCU)
☐ Remote Community
☐ Unhoused / Shelter
☐ Other (Specify):
☐ Deceased / Autopsy
☑ Institution / all group living settings
Facility Name:
☐ 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
Date of symptom onset (yyyy/mm/dd):
☐ Fever
☐ Pneumonia
☐ Cough
☐ Sore Throat
☐ Pregnant
☐ 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 (21/03/09).

Ontario